84-1045

No. _____

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ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

October Term, 1984

MINNESOTA ASSOCIATION OF HEALTH CARE FACILITIES, INC., et al.,

Petitioners,

vs.

MINNESOTA DEPARTMENT OF PUBLIC WELFARE, et al.,

Respondents.

On Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Eighth Circuit

APPENDIX

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APPENDICES

A Denial of Rehearing, United States Court of Appeals for the Eighth Circuit, October 1, 1984

B Opinion and Mandate, United States Court of Appeals for the Eighth Circuit, August 28, 1984

C Judgment, United States District Court, District of Minnesota, Third Division, Judge Edward J. Devitt, September 13, 1983

D Order, United States District Court, District of Minnesota, Third Division , Judge Edward J. Devitt, September 13, 1983

E Judment, United States District Court, District of Minnesota, Third Division, Magistrate Brian P. Short, April 26, 1983

F Order for Judgment, United States District Court, District of Minnesota, Third Division, Magistrate Brian P. Short, April 26, 1983

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H Memorandum, United States District Court, District of Minnesota, Third Division, Magistrate Brian Short, April 26, 1983

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 83-2446-MN.

Minnesota Association of Health Care Facilities, Inc., et al.	*	September Term, 1984
Apellants,	*	Appeal from the United States District Court for the
v.	*	District of Minnesota
Minnesota Department of Public Welfare, et al.	*	
Appellees.	*	

Petition of appellants for rehearing filed in the above case has been considered by the Court and is hereby denied.

October 1, 1984

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 83-2446

Minnesota Association of Health Care Facilities, Inc.; Sunshine Villa, Inc.; Augustana Lutheran Homes, Inc.; Red Wing Nursing Home of TLC Nursing Centers, Inc; Mala Strana Nursing Home of New Prague, and Excelsior Home of Iroquois-Excelsior, Inc.; and Valleyview Nursing Home, Inc.,

Appellants,

v.

Minnesota Department of Public Welfare and Leonard W. Levine, Commissioner of Public Welfare, and Nursing Home Residents' Advisory Council,

Appellees.

No. 83-2447

Minnesota Hospital Association, a non-profit Minnesota corporation;

Appeals from the United States District Court for the District of Minnesota

Canby Community Hospital and C & NC Unit District No. 1, a Minnesota municipal corporation; Divine Providence Hospital and Home, Inc., a non-profit Minnesota corporation; Good Shepherd Lutheran Home of Sauk Rapids, Minnesota, a non-profit Minnesota corporation, and Guardian Angels Foundation of Elk River, Inc., a non-profit Minnesota corporation,

Appellants,

v.

Minnesota Department of Public Welfare and Arthur E. Noot, Commissioner of the Minnesota Department of Public Welfare,

Appellees.

Submitted: April 11, 1984

Filed: August 28, 1984

Before ROSS, ARNOLD and FAGG, Circuit Judges.

FAGG, Circuit Judge.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH COURT

Title page elsewhere

These consolidated actions were brought to challenge the constitutionality of a Minnesota statute which, as a condition of participation in the state's Medicaid program, limits the rates nursing homes may charge residents who do not receive state medical assistance benefits, and retroactively mandates restitution to such residents of charges that exceeded a specified rate differential based on the rates approved by the state for medical assistance recipients. We affirmed the denial of a preliminary injunction, *Minnesota Association of Health Care Facilities, Inc. v. Minnesota Department of Public Welfare*, 602 F.2d 150 (8th Cir. 1979), and following trial by consent before a magistrate, the district court entered judgment for the defendants.

In No. 83-2446, Minnesota Association of Health Care Facilities, Inc. (MAHCF) and the individual plaintiffs contend that the statute violates due process and equal protection guarantees, deprives them of property without just compensation, and unconstitutionally impairs the obligation of contracts. In No. 83-2447, Minnesota Hospital Association (MHA) and the individual plaintiffs challenge only the retroactive "payback provision" of the statue as an unconstitutional impairment of contracts. We hold unconstitutional the part of the statute which retroactively requires refund of collected charges, but reject the remaining constitutional challenges.

I. BACKGROUND

The federal medicaid program authorizes grants to the states to help fund medical assistance programs and specifies requirements for the administration of the state programs. Social Security Act, Title XIX, §§ 1901-1917, 42 U.S.C. §§ 1396-1396p. The Minnesota Department of Public Welfare administers the Minnesota state plan for medical assistance. A system of reimbursement to nursing homes for their care of medical assistance recipients is established by departmental regula-

tions. *See* Minnesota Rules, ch. 9510 (1983) (formerly 12 Minn. Code Agency R. § 2.049). The regulations specify criteria for prospective determination of the per diem reimbursement rate to a nursing home for each resident in its care receiving medical assistance. In this appeal the plaintiffs do not challenge these regulations.

If a nursing home chooses to participate in the Medicaid program it must comply with conditions established by Minn. Stat. § 256B.48. On April 13, 1976, the Minnesota legislature approved the following pertinent language:

> Subdivision 1. No nursing home shall be eligible to receive medical assistance payments unless it agrees in writing that it will refrain from:
>
> (a) Charging nonmedical assistance residents rates for similar services which exceed by more than ten percent those rates which are approved by the state agency for medical assistance recipients; effective July 1, 1978, no nursing home shall be eligible for medical assistance if it charges nonmedical assistance recipients rates for similar services which exceed those which are approved by the state agency for medical assistance recipients; provided, however, that the nursing home may (1) charge nonmedical assistance residents at a higher rate for a private room, and (2) charge for special services which are not included in the daily rate if medical assistance patients are charged separately at the same rate for the same services in addition to the daily rate paid by the state agency; * * *

Minn. Stat. § 256B.48 (1976) (amended 1977, 1978, 1983).

The magistrate found that following enactment of this provision consumers complained that some nursing homes raised to the statutory limit the rates charged residents not receiving state medical assistance. In 1977, the legislature amended section 256B.48 by adding the underlined language below:

> (a) Charging nonmedical assistance residents rates for similar services which exceed by more than ten percent those rates which are approved by the state agency for medical assistance recipients. For nursing homes charging nonmedical assistance residents rates less than ten percent more than those rates which are approved by the state agency for medical assistance recipients, the maximum differential in rates between nonmedical assistance residents and medical assistance recipients shall not exceed that differential which was in effect on April 13, 1976. If a nursing home has exceeded this differential since April 13, 1976, it shall return the amount collected in excess of the allowable differential stated by this subdivision to the nonmedical assistance residents, or that person's representative, by July 1, 1977. Effective July 1, 1978, no nursing home shall be eligible * * *

Minn. Stat. § 256.48 (1) (a) (1977) (amended 1978, 1983).

II. DUE PROCESS

MAHCF contends that by limiting the rates charged to residents not receiving medical assistance the statute, in combination with an already inadequate level of reimbursement provided nursing homes under state regulations for their care of medical assistance recipients, deprives Minnesota nursing homes of substantive due process and results in a taking of their property without just compensation in violation of the Fifth and Fourteenth Amendments. Although MAHCF now also maintains that the statute contravenes similar provisions of the Minnesota Constitution, these state constitutional claims were not advanced in MAHCF's second amended complaint and we do not consider them on appeal.

With respect to the claim of an uncompensated taking, MAHCF urges that we examine the scheme of reimbursement under the principles enunciated in cases dealing with the regulation of rates charged by public utilities:

> Rates which are not sufficient to yield a reasonable return on the value of the property used at the time it is being used to render the service are unjust, unreasonable and confiscatory, and their enforcement deprives the public utility company of its property in violation of the Fourteenth Amendment.

Bluefield Water Works & Improvement Co. v. Public Services Commission, 262 U.S. 679, 690 (1923). The extent of state regulation of the standards of operation for nursing homes and of the rates charged by them are cited by MAHCF as reasons for treating public utilities and nursing homes similarly with respect to state rate regulation.

Cases concerning public utilities are inappropriate, however, because the present case simply does not involve a forced taking of property by the state. Minnesota nursing homes, unlike public utilities, have freedom to decide whether to remain in business and thus subject themselves voluntarily to the limits imposed by Minnesota on the return they obtain from investment of their assets in nursing home operation. *Cf. Permian Basin Area Rate Cases*, 390 U.S. 747, 772-73 (1968) (in examination of area maximum rates it was pertinent that abandonment of unprofitable activities may be permitted). Moreover, the state does not require that nursing homes admit medical assistance residents and participate in the Medicaid program. It is, of course, only through voluntary participation in the state's Medicaid program that a nursing home falls within the purview of section 256B.48 (1) (a). "If appellants find that the reimbursement rates are insufficient, then they may either make their homes more efficient and economical or terminate their relationship with Medicaid and no longer accept Medicaid recipients as residents." *Minnesota Association of Health Care Facilities, Inc. v. Minnesota Department of Public Welfare, supra*, 602 F.2d at 154. MAHCF contends that business realities prevent nursing homes from leaving the Medicaid program voluntarily. Despite the strong financial inducement to participate in Medicaid, a nursing home's decision to do so is nonetheless voluntary. This voluntariness forecloses the possibility that the statute could result in an imposed taking of private property which would give rise to the constitutional right of just compensation, and thus it is unnecessary in this case to employ the adequacy standards applicable to state regulation of public utility rates.

MAHCF argues that even if participation in the Medicaid program is voluntary, the statute impermissibly conditions such participation on the relinquishment by nursing homes of constitutional rights. To be sure, a state may not condition the grant of a privilege or benefit upon the surrender of a constitutional right. *See Western & Southern Life Insurance Co. v. State Board of Equalization*, 451 U.S. 648, 657-58, 664-65 (1981); *Sherbert v. Verner*, 374 U.S. 398, 404-05 (1963); *Frost & Frost Trucking Co. v. Railroad Commission*, 271 U.S. 583, 592- 93 (1926). In the present case the privilege or benefit involved is participation in the Medicaid program, with consequent reimbursement for care of medical assistance residents. As a condition of participation the state requires that a nursing home agree to abide by the statutory provisions concerning rates charged residents who do not receive medical assistance. Hence, as we examine the constitutionality of the statute we will consider whether compliance with the statutory regulation of rates, imposed as a condition of Medicaid participation, compels the relinquishment of constitutional rights that nursing homes would otherwise have.

We begin by observing that nursing homes that serve medical assistance recipients have no constitutional right to be free from state controls on the rates they charge resident who do not receive medical assistance. "The Constitution does not guarantee the unrestricted privilege to engage in a business or to conduct it as one pleases. * * *. [T]he right to conduct a business, or to pursue a calling, may be conditioned." *Nebbia v. New York*, 291 U.S. 502, 527-28 (1934) (footnote omitted). Just as in *Nebbia* the state was permitted to regulate the price of milk, in the present case Minnesota may regulate the rates charged by nursing homes so long as the regulation does not violate constitutional restraints. *See id.* at 525.

Notwithstanding MAHCF's argument to the contrary, we believe the statute meets substantive due process requirements. "If the laws passed are seen to have a reasonable relation to a proper legislative purpose, and are neither arbitrary nor discriminatory, the requirements of due process are satisfied, and judicial determination to that effect renders a court *functus officio*." *Nebbia v. New York, supra*, 291 U.S. at 537, *see North Dakota State Board of Pharmacy v. Snyder's Drug Stores, Inc.*,414 U.S. 156, 164-67 (1973); *Ferguson v. Skrupa*, 372 U.S. 726, 728-32 (1963); *Williamson v. Lee Optical Co.*, 348 U.S. 483, 488 (1955). The Minnesota legislature could reasonably find that differences in rates for the same nursing home services, depending wholly upon whether or not a resident receives medical assistance, are inimical to the public welfare, and thus it could properly choose to regulate the rates that nursing homes participating in Medicaid charge to residents who do not receive medical assistance. The statute enacted to achieve this purpose has a rational relationship to the end sought and is not arbitrary or impermissibly discriminatory. Because the statutory rate limitations survive substantive due process scrutiny, nursing homes are not required to relinquish the constitutional right to due process as a condition of participation in the Medicaid program.

III. EQUAL PROTECTION

MAHCF also contends that the statute violates equal protection because only those nursing homes that participate in the Medicaid program are subject to the restrictions imposed by the statute on the rates charged to residents who do not receive medical assistance benefits. The statute does not apply to nursing homes that have no residents who are Medicaid recipients. Nor does it require a similar equalization of rates for other providers of health care that serve recipients of medical assistance benefits; i.e., hospitals, pharmacies, laboratories, boarding care facilities, and facilities for the mentally retarded. Because it regulates the rates of nursing homes that participate in Medicaid, but not the rates and charges of other nursing homes and health care providers,

MAHCF maintains that the statute establishes classifications that are impermissible under the equal protection guarantees of the United States Constitution and the Minnesota Constitution. Once again, however, MAHCF's state constitutional claim was not raised in the pleadings below and thus our discussion of its equal protection challenge to the statute will be limited to those principles enunciated under the Fourteenth Amendment.

The statute under attack involves economic regulation, and the parties agree that the applicable equal protection standard of review is the rational basis test. The pertinent constitutional principles are well-established and may be briefly stated. The rational basis test "require[s] only that the classification challenged be rationally related to a legitimate state interest." *New Orleans v. Dukes*, 427 U.S. 297, 303 (1976); *see Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 461-63 (1981); *Vance v. Bradley*, 440 U.S. 93, 97 (1979). In addition, "rational distinctions may be made with substantially less than mathematical exactitude." *New Orleans v. Dukes, supra*, 727 U.S. at 303. Consistent with equal protection principles, a legislature may deal with a problem one step at a time, addressing that part of the problem which seems most serious, *see id.; Williamson v. Lee Optical Co., supra*, 348 U.S. at 489, or it may select by one phase of a field of business activity for regulation while neglecting the others. *Id.* The questions before us is whether upon examination the statute meets these established standards of equal protection review.

As we have observed, the statute promotes a legitimate state interest in controlling the rates that nursing homes participating in Medicaid charge residents who do not receive medical assistance. More specifically, the magistrate found that the statute (1) reduces discrimination against Medicaid recipients in gaining entry to nursing homes by eliminating the incentive to discriminate; (2) alleviates the stigma attached to receiving welfare benefits; (3) permits private pay residents to stretch their savings farther and thus stay off welfare; (4) promotes the fundamental notion of fairness that one should pay equal rates for the same services; and (5) eases the resentment of Medicaid recipients by residents who do not receive medical assistance. MAHCF contends

that the distinctions made by the statute are invalid because the purposes would also have been furthered by regulating the rates charged by nursing homes that do not participate in Medicaid, and by imposing on all health care providers who participate in Medicaid the restriction that charges to consumers not receiving medical assistance cannot exceed the charges allowed for Medicaid recipients. According to MAHCF there was no rational basis for limiting the application of the statute to nursing homes participating in Medicaid since the reasons for the statute apply to other health care providers as well.

As for the classifications resulting from the statute, the legislature could rationally have believed that the problems arising from rate discrepancies were most serious in nursing homes that participate in Medicaid, and that it was not necessary or desirable to regulate the rates of other nursing homes or to impose a similar equalization requirement on other health care providers who participate in Medicaid. The rates nursing homes charge Medicaid recipients are limited by the state reimbursement formula, but absent regulation a nursing home could charge residents not receiving medical assistance higher rates in order to achieve a desired level of revenue. Residents who did not receive a state subsidy would thus contribute disproportionately to the home's income. The state could properly move to remedy what it perceived as unfairness in such disproportionate charges for the same services. It was only necessary to include nursing homes that participate in medicaid within the purview of the remedial measure, however, since this kind of rate discrepancy presumably would not exist in nursing homes occupied only by residents not receiving medical assistance. The legislature could also have rationally concluded that because of differences in the nature and cost of services provided, discrepancies in charges by nursing homes participating in Medicaid presented a greater possibility of economic and personal harm to consumers than would similar discrepancies in the charges of other health care providers, apart from nursing homes, that participate in Medicaid. Minnesota was not forbidden to deal with the issue of health care costs by attacking but part of the problem. "[I]n the local economic sphere, it is only the invidious discrimination, the wholly arbitrary act, which cannot stand consistently with the Fourteenth Amendment." *New Orleans v. Dukes,*

supra, 427 U.S. at 303-04. The classifications established by the Minnesota statute are neither invidious nor arbitrary, and hence not violative of equal protection.

IV. IMPAIRMENT OF CONTRACTS

We now turn to the question of whether, by making compliance with its terms a condition of Medicaid participation, section 256B.48 (1) (a) impairs the obligation of contracts in violation of article I, section 10 of the United States Constitution. MAHCF challenges as an unconstitutional impairment of contracts all statutory restrictions imposed on rates charged by nursing homes to residents not receiving medical assistance, while MHA challenges only that part of the statute which requires restitution of amounts exceeding the allowable rate differential established retroactively by the statute. Our discussion will be limited to private contracts between residents and nursing homes. Although MAHCF also contends that the statute unconstitutionally impairs basic provider agreements between the state and individual nursing homes by requiring them to sign supplemental provider agreements incorporating the terms of section 256B.48 (1) (a) as a condition of participating in the Medicaid program, we do not consider this contention because we have not been furnished any example of the basic agreements that it is argued are impaired.

As we consider whether the statute impermissibly impairs contracts between nursing homes and their residents, we will, for the time being, put aside consideration of the retroactive restitution requirement and deal with MAHCF's challenge to the remaining rate limitations of the statute. The gist of MAHCF's argument is that by placing limits on rates that nursing homes may charge residents who do not receive medical assistance, the statue alters the terms of agreements reached by private parties. From the briefs and record it appears that some of these agreements include a specified rate for services, and thus a new agreement would be required if the rate were to be changed. Other

agreements specify a given rate, but also include provisions that allow the nursing home to change the rate without entering into a new contract. While the statute would limit the collection of rates specifically established by agreements in existence before the statute became effective, if above the statutory maximum, it is clear from MAHCF's reply brief that the nursing homes' principal concern is the limitation that the statute places on their contractually authorized periodic adjustment of rates. MAHCF contends that when the contracts were signed it was not contemplated that such rate adjustment would be subject to limitation by the state.

In numerous cases the Supreme Court has articulated principles applicable to analysis of state laws under the contract clause. Although the language of the contract clause is unequivocal, the limitation it imposes is "not an absolute one and is not to be read with literal exactness like a mathematical formula." *Home Building & Loan Association v. Blaisdell*, 290 U.S. 398, 428 (1934). It has long been recognized that the prohibition of laws impairing the obligation of contracts does not prevent states from acting pursuant to their inherent police power to promote the public welfare. *See Energy Reserves Group Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 410 (1983); *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 241 (1978); *United States Trust Co. v. New Jersey*, 431 U.S. 1, 21-22 (1977); *Blaisdell, supra*, 290 U.S. at 434-35; *Manigault v. Springs*, 199 U.S. 473, 480 (1905). If the states did not have this power to enact general regulatory measures, despite their impairment of destruction of private contracts, it would be possible "to obtain immunity from state regulation by making private contractual arrangements." *United States Trust Co., supra*, 431 U.S. at 22. "One whose rights, such as they are, are subject to state restriction, cannot remove them from the power of the State by making a contract about them." *Hudson Water Co. v. McCarter*, 209 U.S. 349, 357 (1908). We have already decided that consistent with due process and equal protection the rates charged by nursing homes that participate in the Medicaid program may be regulated by the state, and thus we now consider whether this exercise of the policy power effects an unconstitutional impairment of contracts.

The first step in the constitutional analysis is to determine "whether the state law has, in fact, operated as a substantial impairment of a contractual relationship." *Allied Structural Steel Co., supra,* 438 U.S. at 244, *quoted in Energy Reserves Group, supra,* 459 U.S. at 411. The more severe the impairment of contract worked by the law, the greater the level of scrutiny given it. *Energy Reserves Group, supra,* 459 U.S. at 411; *Allied Structural Steel Co., supra,* 438 U.S. at 245. Substantial impairment may result even though there is no total destruction of contractual expectations. *Energy Reserves Group, supra,* 459 U.S. at 411; *United States Trust Co., supra,* 431 U.S. at 26-27. One consideration in determining whether the impairment is substantial is the extent to which reasonable expectations under the contract are disrupted. *See Energy Reserves Group, supra,* 459 U.S. at 411; *Allied Structural Steel Co., supra,* 438 U.S. at 245-47; United States Trust Co., supra, 431 U.S. at 31; *El Paso v. Simmons,* 379 U.S. 497, 515 (1965).

If the law causes a substantial impairment the inquiry moves to the state's justification for its action. *See Energy Reserves Group, supra,* 459 U.S. at 411. Regulation of existing contractual relationships must serve a significant and legitimate public purpose. *See id.; United States Trust Co., supra,* 431 U.S. at 22; *Blaisdell, supra,* 290 U.S. at 444-45. "The requirement of a legitimate public purpose guarantees that the State is exercising its police power, rather than providing a benefit to special interests." *Energy Reserves Group, supra,* 459 U.S. at 412. Thus the Court has considered whether the impairment serves to remedy "an important general social problem," *Allied Structural Steel Co., supra,* 438 U.S. at 247, or "to protect a broad societal interest rather than a narrow class." *Id.* at 249. In *Blaisdell, supra*, the Court noted that the law it upheld "was not for the mere advantage of particular individuals but for the protection of a basic interest of society." 290 U.S. at 445. Ultimately, it must be determined whether the means chosen to achieve the legitimate public purpose survives constitutional scrutiny. "Legislation adjusting the rights and responsibilities of contracting parties must be upon reasonable conditions and of a character appropriate to the public purpose justifying its adoption." *United States Trust Co., supra,*

431 U.S. at 22, *citing Blaisdell, supra,* 290 U.S. at 445-47. Deference is given to the legislative judgment concerning the necessity and reasonableness of economic and social regulations which affects private contracts. *See Energy Reserves Group, supra,* 459 U.S. at 412-13; *United States Trust Co., supra,* 431 U.S. at 22-23.

When we apply these principles to section 256B.48 (1) (a), we conclude that those provisions of the statute which have prospective application are constitutional. We believe that consistent with the contract clause Minnesota could limit the differential between rates for residents receiving medical assistance and those not receiving it to 10 percent or to the differential in effect on April 13, 1976, and that after July 1, 1978, the state could equalize the rates for these two categories of nursing home residents. Initially, we doubt that the law causes a substantial impairment of contractual relationships. Nursing homes could not reasonably expect that the terms of whatever contracts they had with their residents would exempt them from rate regulation by the state. As we have noted, MAHCF is chiefly concerned with the statutory limitations on the freedom of nursing homes periodically to increase their rates by amounts not specified in resident contracts. It is unlikely that this limitation of rate increases would substantially impair reasonable, settled contractual expectations. Even if the impairment is substantial, however, the state's interest in controlling rates charged by nursing homes provides a legitimate public purpose for the statute. Without the statute nursing homes could charge residents not receiving medical assistance higher rates in order to compensate for what they consider to be inadequate Medicaid reimbursement. In view of the state's objective of providing adequate compensation to prudently managed nursing homes, see *Minnesota Rules, supra,* § 9510.0020, the legislature could prohibit nursing homes from making unsubsidized residents bear the burden of inefficient nursing home operation. Legitimate exercise of the police power includes ensuring that state efforts to assist some nursing home residents do not work to the detriment of other residents. In addition, the class of persons benefitted by the

statute is certainly not so narrow that it may be deemed special interest legislation. The statute truly deals with an important general social problem and serves to protect a basic interest of society. Finally, particularly in view of the gradual implementation of the rate limitations, we cannot say that the adjustment of contract rights effected by the statute involves unreasonable conditions or is inappropriate to the public purpose it serves.

We now return to the question of whether an unconstitutional impairment of contracts results from that part of the statute which retroactively requires restitution of charges in excess of the differential in effect April 13, 1976. We believe that it does. This aspect of the statute does cause substantial impairment of contractual relationships, for the rates charged were not unlawful at the time they were collected, and nursing homes could reasonably have expected that pursuant to agreements with their residents they were entitled to these funds. We will assume that the state's interest in controlling rates charged by nursing homes participating in Medicaid provided a legitimate public purpose for the restitution provision, although it does appear that this part of the statute has a considerably narrower focus than do other parts. Ultimately, however, we believe the adjustment of contract rights made by the retroactive part of the statute is not upon reasonable conditions or of a character appropriate to the public purpose identified. Because of its retroactivity, the statute imposes totally unexpected liability on nursing homes for charges that were permitted by law when collected. This statute goes too far because it disrupts settled and completed financial arrangements under contracts made in reliance on existing law. The retroactive payback provision is invalid.

Affirmed in part and reversed in part.

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CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT.

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United States District Court

DISTRICT OF MINNESOTA
THIRD DIVISION

JUDGMENT IN A CIVIL CASE

CV. 3-77-467

Minnesota Association of Health Care Facilities, Inc., et al.

v.

Excelsior Nursing Home of Iroquois-Excelsior, Inc.; et al.

EDWARD J. DEVITT, Judge

This action came to trial or hearing before the Court with the judge (magistrate) named below presiding. The issues have been tried or heard and a decision has been rendered.

It is ordered and adjudged that Pltffs and Pltff Intervenors recover nothing by their complaint and this action is dismissed with prejudice; Defts & Defts Intervenor are entitled to judgment and to the recovery from pltffs & pltff intervenors of their costs & disbursements as taxed and allowed.

Dated: September 13, 1983

Robert E. Hess, Clerk

United States District Court

DISTRICT OF MINNESOTA
THIRD DIVISION

ORDER

Civ. 3-77-467

Minnesota Association of Health Care Facilities, Inc.; Sunshine Villa, Inc.; Augustana Lutheran Homes, Inc.; Red Wing Nursing Home of TLC Nursing Centers, Inc; Mala Strana Nursing Home of New Prague,

Plaintiffs,

and

Excelsior Nursing Home of Iroquois-Excelsior, Inc.; and Valleyview Nursing Home, Inc.,

Plaintiff Intervenors,

v.

Minnesota Department of Public Welfare and Leonard W. Levine, Commissioner of Public Welfare,

Defendants,

and

Nursing Home Residents' Advisory Council,

Defendant-Intervenor.

John M. Broeker, Esq., Steve M. Mihalchick, Esq., and Frances Long Robinson, Esq., Broeker, Hartfeldt, Hedges & Grant, for plaintiffs and plaintiff intervenors

Brad Engdahl, Esq., Special Assistant Attorney General, for defendants.

Laurie N. Davison, Esq., Legal Aid Society of Minneapolis, for defendant-intervenor.

Plaintiffs and plaintiff-intervenors take issue with the magistrate's findings and conclusions,

(1) that participation in the Medicaid program by nursing homes in Minnesota is voluntary;

(2) that enforcement of Minn. Stat. §256B.48(1)(a) does not unconstitutionally deprive nursing homes in Minnesota of property without due process of law;

(3) that enforcement of Minn. Stat §256B.48(1)(a) does not unconstitutionally deny nursing homes in Minnesota equal protection of the law; and

(4) that enforcement of Minn Stat. §256B.48(1)(a) does not unconstitutionally impair the obligation of contracts.

The court has considered each of plaintiffs' and plaintiff-intervenors' arguments and defendants' and defendant-intervenor's response.

Based on the magistrate's memorandum and findings and conclusions, the court's *de novo* review, and all files, records and proceedings herein, and a full consideration of legal briefs of the parties,

IT IS ORDERED THAT:

(1) Plaintiffs and plaintiff-intervenors recover nothing by their complaint and this action is dismissed with prejudice;

(2) Defendants and defendant-intervenors are entitled to judgment and to the recovery from plaintiffs and plaintiff-intervenors of their costs and disbursements as taxed and allowed.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: September 13, 1983

EDWARD J. DEVITT, Judge,
United States District Court

United States District Court

DISTRICT OF MINNESOTA
THIRD DIVISION

JUDGMENT IN A CIVIL CASE

CV 3-77-467

Minnesota Association of Health Care Facilities, Inc., et al.

v.

Minnesota Department of Public Welfare

SHORT, Magistrate

This action came to trial or hearing before the Court with the judge (magistrate) named above presiding. The issues have been tried or heard and a decision has been rendered.

It is ordered and adjudged that pltffs and pltff-intervenors recover nothing by their complaint and this action is dismissed with prejudice; defts & deft-intervenor are entitled to judgment and to the recovery from pltffs & pltff-intervenors of their costs & disbursements as taxed and allowed.

Dated: April 26, 1983

Robert E. Hess, Clerk

United States District Court

DISTRICT OF MINNESOTA
THIRD DIVISION

ORDER FOR JUDGMENT

Civil 3-77-467

Minnesota Association of Health Care Facilities, Inc.; Sunshine Villa, Inc.; Augustana Lutheran Homes, Inc.; Red Wing Nursing Home of TLC Nursing Centers, Inc.; Mala Strana Nursing Home of New Prague,

Plaintiffs,

and

Excelsior Nursing Home, of Iroquois-Excelsior, Inc.; and Valleyview Nursing Home, Inc.,

Plaintiff-Intervenors,

v.

Minnesota Department of Public Welfare; Arthur E. Noot, Commissioner of Public Welfare,

Defendants,

and

Nursing Home Residents' Advisory Council

Defendant-Intervenor

The Clerk of Court is directed to enter judgment in this cause in the following form:

IT IS ORDERED, ADJUDGED AND DECREED that plaintiffs and plaintiff-intervenors recover nothing by their complaint and this action is hereby dismissed with prejudice.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that defendants and defendant-intervenors are entitled to judgment and to the recovery from plaintiffs and plaintiff-intervenors of their costs and disbursements as taxed and allowed.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: April 26, 1983

BRIAN P. SHORT
United States Magistrate

United States District Court

DISTRICT OF MINNESOTA
THIRD DIVISION

FINDINGS OF FACT AND
CONCLUSIONS OF LAW

Civil 3-77-467

Minnesota Association of Health Care Facilities, Inc.; Sunshine Villa, Inc.; Augustana Lutheran Homes, Inc.; Red Wing Nursing Home of TLC Nursing Centers, Inc.; Mala Strana Nursing Home of New Prague,

Plaintiffs,

and

Excelsior Nursing Home, or Iroquois-Excelsior, Inc.; and Valleyview Nursing Home, Inc.;

Plaintiff-Intervenors,

v.

Minnesota Department of Public Welfare; Arthur E. Noot, Commissioner of Public Welfare,

Defendants.

and

Nursing Home Residents' Advisory Council,

Defendant-Intervenor.

Civil 3-78-88 *

Minnesota Hospital Association; Canby Community Hospital and C & NC Unit District No. 1; Divine Providence Hospital and Home, Inc.; Good Shepherd Lutheran Home of Sauk Rapids, Minnesota; Guardian Angels Foundation of Elk River, *

Plaintiffs, *

v. *

Minnesota Department of Public Welfare and Arthur E. Noot, Commissioner of Public Welfare, *

Defendants. *

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I. INTRODUCTION

A. *Procedural History*

1. Complaint filed - October 26, 1977

2. Cross-motions for summary judgement denied - Memorandum and Order, September 11, 1978.

3. Plaintiffs' motion for preliminary injunction denied - Memorandum and Order, October 20, 1978.

4. Plaintiffs' motion for reconsideration denied - November 6, 1978.

5. Plaintiffs' appeal of denial of preliminary injunction to Eighth Circuit denied. *MAHCF v. MDPW*, 602 F.2d 150 (8th Cir. 1979).

6. Plaintiffs' motion for rehearing and rehearing *En Banc* denied by Eighth Circuit - July 30, 1979.

7. Plaintiffs' motion for Special Master denied, Memorandum and Order, October 23, 1979.

8. Plaintiffs' second motion for preliminary injunction denied September 15, 1980, with Findings of Fact and Conclusions of Law.

9. Referral to HHS of the reasonable cost-relatedness of Rule 49 and plaintiffs' motion to amend granted in part and denied in part. Memorandum and Order, October 15, 1980.

10. Plaintiffs' motion for order specifying the duties of HHS denied - Memorandum and Order, December 24, 1980.

11. Plaintiffs' second motion to amend granted - Memorandum and Order, April 30, 1981.

B. *Background*

1. Plaintiff Minnesota Association of Health Care Facilities (MAHCF) is an association consisting of approximately 178 proprietary and non-proprietary nursing homes and boarding care facilities in Minnesota, and it has standing to pursue the relief sought by plaintiffs and plaintiff-intervenors herein.

2. Plaintiff Minnesota Hospital Association, Minnesota Association of Homes for the Aging (MHA) is an association consisting of 217 non-proprietary nursing homes, and it has standing to pursue the relief sought by plaintiff in Civil No. 3-78-88.

3. In 1980, there were 440 nursing homes in Minnesota. The vast majority of those nursing homes, 438 in 1980, participated in Medicaid. The individual plaintiff nursing homes all participate in Medicaid and are proper parties to this action.

4. The Medicaid Act, Title XIX of the Social Security Act (42 U.S.C. §1396 *et seq.*), established a cooperatively funded and administered program, among the federal, state and local governments, to enable states to furnish Medicaid Assistance or Medicaid to and on behalf of aged, blind or disabled individuals whose income resources are insufficient to meet the costs of necessary medical services. Pursuant to statutory formulae, the federal and state governments share the costs of such aid. Defendant Department of Public Welfare (DPW) is the state agency responsible for administration of the program in Minnesota.

5. Rule 49 allows a competent administrator to adjust cost expenditures so as to come within the amount allowed by the state in its reimbursement rate.

6. A provider calculates its own proposed rate and includes that rate in its cost report at the time of filing. Jt. exs. 55-62.

7. This proposed rate may undergo some adjustments during the first part of the rate year. These adjustments may increase or decrease the rate allowed. No evidence was submitted indicating that a competent administrator is unable to initiate cost-saving devices on the basis of this proposed rate rather than waiting for any DPW adjustments to that rate.

8. That a nursing home's known cost changes may be subjected to a retrospective payback is irrelevant to the inquiry as to whether a competent manager is able to operate within the prospective rate established by Rule 49. Whether a competent manager is able to operate within the prospectively established rate addresses whether a facility must expend *more* than that allowed by the Rule. A retrospective payback is implicated only if a facility expends *less* than that allowed by Rule 49 and the providers' projections.

9. The number of nursing homes in Minnesota and the percentage of those homes participating in Medicaid has been relatively constant in the years 1975-1978. The number of proprietary homes has remained at a consistent level as well. Jt. Ex. 51

10. In 1980, 438 of the 440 nursing homes in the State of Minnesota participated in Medicaid. Of these 438 homes, 163 were proprietary. Jt. Ex. 51.

11. In 1979, 436 of the 438 nursing homes in the State of Minnesota participated in Medicaid. Of these 436 homes, 157 homes were proprietary. Jt. Ex. 51.

12. In 1976, 442 of the 443 nursing homes in the State of Minnesota participated in Medicaid. Of these 442 homes, 168 were proprietary. Jt. Ex. 51.

13. The percentage of Medicaid patients in the nursing home industry in Minnesota ranged between 60 percent and 64.8 percent for the years 1975 through 1979. Jt. Ex. 51.

14. In 1981, Minnesota spent $314,538,000 (54%) of its $587,000,000 Medicaid budget on skilled and intermediate nursing home care.

15. Plaintiff MAHCF is comprised of 178 nursing and boarding care facilities, the majority of which are proprietary. Plaintiff MHA is comprised of 217 nursing and C&NC (hospital-attached) units, all of which are non-profit. Plaintiff MHA challenges the legality of the payback provision found in §256B.48.

16. The court has filed today a Memorandum in support of these findings of Fact and Conclusions of Law. The court specifically adopts as additional findings the factual assertions in that Memorandum.

II. SUMMARY OF FINDINGS

A. *The Equalization Statute - Minn. Stat. §256B.48*

1. The Private Pay Law does not deprive plaintiffs or plaintiff-intervenors of due process of law.

2. The enforcement of the Private Pay Law does not violate the equal protection clauses of the Constitutions of the United States and of the State of Minnesota.

3. The enforcement of the Private Pay Law does not unconstitutionally impair the obligation of contracts.

4. The Private Pay Law does not impose an illegal condition on participation in the Medicaid Program.

B. *The Minnesota Medicaid Reimbursement System - Rule 49*

1. The Minnesota Medicaid Reimbursement System provided for reimbursement to providers of skilled nursing and intermediate care nursing services on a reasonable cost-related basis through September 30, 1980.

2. The Minnesota Medicaid Reimbursement System provided for reimbursement to providers of skilled nursing and intermediate care nursing services at rates which were reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

3. The Minnesota Medicaid Reimbursement System has been reviewed and verified by the Department of Health and Human Services as required by law.

III. THE EQUALIZATION STATUTE (PRIVATE PAY LAW) - MINN. STAT. §256B.48

A. *The Private Pay Law Does Not Deprive Plaintiffs or Plaintiff-Intervenors of Due Process of Law.*

1. The burden of proving a due process violation rests on the plaintiff who must show: 1) that they are entitled to a rate of return; 2) that the rate of return does not compare with similar ventures in similar geographical areas; and 3) that the challenged rate actually results in their being unable to meet their legitimate expenses.

2. Participation in the nursing home industry is voluntary.

a. There are no laws or regulations which require that a nursing home provide its services to the public.

b. Nursing home owners can and do leave the industry voluntarily.

3. Participation in the Medicaid Program is voluntary.

a. Nursing homes are not entitled to any rate of return by virtue of their particpation in Medicaid.

b. There are no requirements that a nursing home in Minnesota participate in the Medicaid Program.

c. Plaintiffs have testified that it is in their economic interest to participate in Medicaid but this does not make their participation in the program any the less voluntary.

4. Plaintiffs have established no due process violation.

a. With respect to proprietary homes, plaintiffs have not submitted any evidence as to comparable rates of return of similar ventures.

b. Mr. Richard Kahan and Dr. Barry Griffin both explicitly admitted that they had no conclusions as to the profitability of the Minnesota nursing home industry.

c. The MSRI Study sheds no light on due process issues for the following reasons:

i. It compares projected revenues with projected costs and therefore is unable to take into consideration the fact that an administrator may adust a facility's projected expenses in accordance with the prospective reimbursement rate. It does not show that the Minnesota Medicaid Reimbursement System actually results in a due process violation.

ii. The MSRI Study does not examine Rule 49 as a whole. It only analyzes certain cost limitations imposed by the Rule.

iii. The MSRI Study overstates the effects of the disallowances that it examines by treating even computational mistakes of the provider as a disallowance under the Rule.

iv. Table I of the MSRI Study is not profit/loss analysis.

v. If Table I were analyzed as a profitability study, however, it would indicate the following:

1) although it purports to show that the "estimated average income" of a facility was a negative $401, this figure misleadingly includes non-profit homes in its average; 2) an examination of the cost reports of proprietary facilities reveals that the "estimated average income" jumps to $16,116 (excess of revenue over historical costs per books plus self-allowed cost changes); 3) if the excess of revenues over reasonable costs is measured, the "income" is $49,045.

d. The testimony of the providers does not show reimbursement to be insufficient.

i. The providers' ability to maximize revenues over expenses is not tied to Rule 49 or the Equalization Statute. Augustana Lutheran, a provider, was able to achieve significant revenues over expenses in the years after the effective date of the Equalization Statute - ($69,404 in 1979 and $102,738 in 1980).

ii. The relevant variables which affect profit or loss appear to be occupancy and administrative ability of management, rather than the level of reimbursement provided by the Minnesota Medicaid Reimbursement System. There is no direct correlation in the homes' financial statements relating profit or loss to Rule 49 and the Equalization Statute. Jt. Exs. 55-62; D. Ex. 2. For instance, Sunshine Villa, a home which had been profitable, was experiencing a financial loss in the early part of 1981 because of occupancy difficulties and not because of any difficulty within Rule 49 or the Equalization Statute.

e. Analysis of the nursing home industry in Minnesota establishes that it is a viable business enterprise.

i. Nursing home sales have occured at a constant pace throughout the duration of this lawsuit and have not suffered any decline because of the Equalization Statute.

ii. The nursing home industry has numerous possibilities for financial benefit in addition to annual profits derived from patient care. These benefit include:

1) The ability to receive a higher salary than that which would be paid in an arm's-length transaction. Ps. ex. 22.

2) Nursing home owners are able to use their corporate control in order to receive consultant's fees from the corporation.

3) Nursing homes owners are able to use the equity in their nursing home in connection with other unrelated investments.

5. There is no due process right to charge non-Medicaid patients a higher rate than that charged Medicaid patients.

6. Plaintiffs submitted no evidence indicating that they were unable to meet all their legitimate expenses as a result of Rule 49 and the Equalization Statute.

a. HSS found the reimbursement allowed by Rule 49 to be generous.

b. Plaintiffs' evidence establishes only that certain costs are disallowed in the establishment of the next year's rate. The fact that such costs are disallowed does not indicate that the nursing home will not be able to meet its expenses. For example, a nursing home may have some top management compensation disallowed particularly if the administrator is the owner. However, there was no evidence submitted by plaintiffs indicating that the salaries reimburses would have been insufficient to allow the nursing home to hire a competent and qualified administrator. Plaintiffs' Exhibit 22 established that competent administrators could be and were hired and retained at a salary level from which no disallowance would be made.

c. Similarlly, there was no evidence with respect to any other cost report line item which would establish that the rate actually allowed by DPW was insufficient to meet legitimate costs. Although plaintiffs' expert, Richard Kahan, attacked the methodology used by the State in determining its reimbursement rule, neither he nor any other person testified that this methodology precluded a nursing home from meeting its legitimate expenditures.

7. The Deloitte Study.

a. The Deloitte Study, at the least, established that there was an opportunity for profit within the nursing home industry in Minnesota. D. Ex. 1a and 1b.

b. In 1976, 76 percent of the proprietary nursing homes in the survey were profitable. *Id.*

c. In 1979, after the implementation of the Equalization Statute, 80 percent of the proprietary nursing homes were profitable. *Id.*

d. The return on equity for proprietary nursing homes was 27.76 percent in 1976 and 86.75 percent in 1979. *Id.*

e. The mean profit from operations for proprietary nursing homes was $47,287 in 1976 and $62,495 in 1979. *Id.*

f. Even when nonprofit and profit homes were computed together, between 56 and 69 percent of the entire population of homes showed an excess of revenue over expenses in 1976 and 68 to 89 percent showed excess of revenue over expenses in 1979. *Id.*

8. Long-term gain.

a. The reimbursement rule also benefits the provider by necessarily providing the opportunity for long-term gain withoutany additional investment by the provider. *Id.* The investment allowance, for example, provides a return on the historical cost of the facility rather than simply a return on the owner's net invested equity. In conjunction with the interest expense, this means that an owner's mortgage payment including principlal will generally be met by the reimbursement rule. A facility that is highly leveraged, therefore, will be able to reap a major investment gain for the owner without significant risk of investment. *Id.*

b. Significant long-term gains were achieved by the nursing home providers. Specifically, Long-Lake and Excelsior Nursing Homes were purchased in 1974 for $276,000 and sold in 1980 for some $1,600,000. Long-term gain in excess of one million dollars was also realized in the sale of Red Wing Nursing Home.

c. In addition, the Deloitte Study showed that there were major long-term gains in its survey of nursing home sales in Minnesota. The average gain on these sales was $747,071. *Id.*

d. The possibility for long-term gains in nursing homes (with attendant tax advantages and owner's salaries) makes investment in a nursing home a viable option even if the home is not profitable in its early operations.

B. *The enforcement of the Private Pay Law does not violate the equal protection clauses of the Constitutions of the United States and of Minnesota.*

1. Minn. Stat. §256B.48 is rationally based and furthers strong societal purposes. The statute was supported before the Minnesota Legislature by the Nursing Home Residents' Advisory Council ("NHRAC") made up of some 13,000 members throughout the State of Minnesota. It was also supported by the Minnesota Senior Federation which has some 150,000 members statewide.

2. The equalization provision: 1) may reduce discrimination against Medicaid recipients in gaining entry to nursing homes by eliminating the incentive to discriminate; 2) tends to alleviate the "stigma" attached to receiving welfare benefits; 3) permits private pay residents to stretch their savings farther and thereby stay off welfare; 4) promotes the fundamental notion of fairness that one should pay equal rates for equal services; and 5) eases the resentment of private pay patients directed toward Medicaid recipients.

3. The Nursing Home Residents' Advisory Council supported the 1977 amendment which required that those nursing homes which had increased their rate differential between private pay and Medicaid patients from the difference that existed in April of 1976, pay back the excess to private pay patients (the "payback" provision). The NHRAC had received complaints from consumers about facilities raising their rates to a 10% differential when there had been a lower differential prior to the enactment of the Equalization Statute. Testimony on behalf of the plaintiff Minnesota Hospital Association revealed that some homes had increased their Medicaid/private pay rate differential to an amount greater than it was in 1976.

4. There are a number of legitimate bases upon which to distinguish between nursing homes and other health care providers:

a. the continuing nature of a nursing home's service to a Medicaid recipient as contrasted with the sporadic aid provided by pharmacies, laboratories, individual physicians and hospitals;
b. all-inclusive care provided by nursing homes and not most other providers;

5. Nursing homes are distinguiable from boarding care homes in terms of occupancy levels, rates and licensure standards.

C. *The enforcement of the Private Pay Law does not unconstitutionally impair the obligation of contracts.*

1. There is no contract clause violation since Medicaid participation in voluntary. Even assuming that the statute affected private pay contracts, such contracts are affected only if the provider decides that it is economically beneficial for it to participate in the Medicaid Program.

2. The payback statute does not directly affect underlying contractual obligations but merely specifies requirements with which a provider must comply if it elects to continue to participate in the Medicaid Program. The payback provision has no direct effect on pre-existing obligations. A provider must refund the increased differential it charged in the years 1976 and 1977 only if it elected to continue to participate in Medicaid.

3. Even if the contract clause is implicated by Minn. Stat. §256B.48, subd. 1(a), the statute nonetheless does not create an unconstitutional impairment because any impairment in this case is not substantial. First, the provision affects only a small proportion of nursing homes. It was stipulated by counsel for MHA that only 20 of 93 nursing homes responding to a survey conducted for this litigation were affected by the payback provision. Second, for those homes affected, the impact is slight. The obligations of the Canby and the Valleyview facilities show obligations of less than 2% of one year's revenues. The obligation is further minimized by the fact the Department of Public Welfare gave providers a lengthy period amounting to several years to sign "supplemental provider agreements" in which providers agreed to comply with the law. The Department has generally insisted upon escrow of the excess charge after April 13, 1976, but in some instances has been flexible even on that point. In calculating the paybacks, the Department allowed the providers to use the percentage rather than absolute dollar method of calculation. For ease of compliance, the Department has used the desk-audited rate as the final Medicaid rate. The Department has given effect to agreements under which the provider obtains prior agreement of a private pay patient to accept adjustment of the private rate to reflect subsequent Medicaid rate adjustments. *See* D. Ex. 20.

4. The payback provision is a reasonable exercise of the State's police power.

5. The payback provision was within the providers' reasonable expectation of regulation. Defendant-Intervenor's Ex. 1. Providers in an industry, such as the nursing home industry, which is subject to pervasive regulation could not reasonably have expected to be free from regulations such as this. Plaintiffs themselves have set forth governmental regulation as a risk within the industry. Nursing home providers are particularly subject to regulation with some retroactive aspects. By the time of enactment of the payback provision, the provision was no surprise to the providers. There had been long-standing and active lobbying for such legislation by highly visible groups of consumers. The nursing home industry groups, including both MHA and MAHCF, were involved in this legislative process. Defendant Intervenor's Ex. 1.

D. *The Private Pay Law is not void for vagueness.*

1. The Department of Public Welfare has allowed the providers to use the percentage rather than an absolute dollar amount in calculating the differential between private statutory and welfare rates. The Department uses the first rates that are "approved"" by the Department following a desk audit. Private pay rates are calculated in the same fashion as they have been throughout the years of the program. The disposition of any refund owing a patient is treated under other provisions to the Minnesota statutes and in the same manner as any other asset. The impact of any refund to a patient who has subsequently become a welfare resident is treated the same as any other Medicaid eligible person who receives some income or assets. The interpretation of the statute made contemporaneously by the agency charged with its administration are long-held and consistently held and well known to the industry.

E. *Condition of Participation.*

1. Minn. Stat. §256B.48 does not violate the Medicaid Act by imposing an illegal condition of participation against additional conditions of eligibility being imposed upon *recipients* found at 42 U.S.C. §1396a(a)(8).

2. HHS approval is not required for Minn. Stat. §256B.48.

b. The plan review process specified by the Standardized Review Criteria and applied in this case includes initial review, dialogue with the State, review of relevant data and an analysis of the individual elements of the state plan and the interaction of each element with the others to determine the overall effect of the plan. Jt. Ex. 33, p. 3.

c. The HSS procedures include detailed objective criteria concerning cost reporting, cost finding, audits, cost allowability, reasonableness criteria, rate-setting methods, classification procedures, indexing and forecasting and other plan provisions which affect the reimbursement rate ultimately developed. Jt. Ex. 33, p. 3

d. In its review of Rule 49, HHS

-analyzed the definitions of allowable costs;
-considered the State's classification system to insure that is reasonably recognized the cost distinctions among facilities;
-considered the reasonableness of the reimbursement ceilings;
-analyzed the inflation indexing to insure that economic conditions and trends during the period reviewed were properly considered.

e. Although the legality of Rule 49 must be viewed as a whole, HHS also reviewed the individual provisions of the Rule. Jt. Ex. 32.

f. The determination that Rule 49 provided reimbursement on a reasonable cost-related basis reflected a comprehensive judgement by HHS based on both the individual components of Rule 49 and the interaction of those components in viewing the Rule as a unified reimbursement mechanism. Jt. Ex. 32, p. 2, 20.

6. In its review and verification of Rule 49, HHS considered voluminous data submitted not only by the State but also by MAHCF.

a. After its initial review of Rule 49, HHS requested additional information in thirteen areas of the Minnesota plan. Jt. Ex. 32, ex. A; Jt. Ex. 34.

IV. PLAINTIFFS' CHALLENGE TO THE MINNESOTA MEDICAID REIMBURSEMENT SYSTEM

A. *The Minnesota Medicaid Reimbursement System either alone or in conjunction with Minn. Stat. §256B.48 does not violate the due process clauses of the Constitutions of the United States and of the State of Minnesota.*

See Findings III A, pages 6 through 10.

B. *The Minnesota Medicaid Reimbursement System provides for reimbursement to providers of skilled nursing and intermediate care nursing services on a reasonable cost-related basis through September 30, 1980, and at rates which were reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities thereafter.*

1. The issues of whether Rule 49 complied with federal law was referred to the Department of Health and Human Services ("HHS") under the doctrine of primary jurisdiction by the District Court in its orders of October 15, 1980 and December 24, 1980.

2. Referral to HHS was ordered because of the agency's acknowledged expertise and competence. Memoranda and Orders of October 15, 1980 and December 24, 1980.

3. HHS' findings of fact and conclusion that Rule 49 has reimbursed nursing services during the period January 1, 1978 through September 30, 1980, on a reasonable cost-related basis are reasonable.

4. HSS' findings of fact and conclusion that Rule 49 has reimbursed nursing services since October 1, 1980 at a level which is reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities are reasonable.

5. HSS properly reviewed and verified Rule 49 for compliance with federal law.

a. This review and verification of Rule 49 was accomplished pursuant to the Standardized Review Criteria for Title XIX Long-Term Care Payment Plans. Jt. Ex. 32, p. 1 and Jt. Ex. 33. These criteria were adopted by HSS is response to and in compliance with the decisions of the United States Court of Appeals for the Fifth Circuit in *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388 (5th Cir. 1980) and *Florida Nursing Home Ass'n v. Page*, 616 F.2d 1355 (5th Cir. 1980).

b. On April 3, 1981, the State submitted its response which explained the operation of portions of Rule 49 which were unclear to HHS, provided the historical bases of certain Rule provisions and included data concerning the operation of specific areas of the Rule. Jt. Ex. 35.

c. On April 8, 1981, MAHCF submitted a response to the request of HHS including the MSRI Study, plaintiffs' exhibit 1, and an affidavit of Richard Kahan which had been filed in this litigation in 1978, as well as various correspondence, memoranda, hearing transcripts and hearing examiner reports regarding Rule 49. These materials were reveiwed by HHS. Jt. Exs. 36 and 36a-k.

d. On April 13, 1981, MAHCF submitted to HHS a response to the State's submission of April 3 which included arguments, data and deposition excerpts. These materials were reviewed by HHS. Jt. Ex. 37.

e. HHS contacted Robert A. Rau, the director of the Audit Division of DPW, on a number of occasions after April 3, 1981, in order to gain a further understanding of the historical bases and administration of Rule 49 from the person primarily responsible for implementing this provision.

f. In response to the telephone inquiries of HHS, the State submitted additional data on April 19, 1981 which described the bases, operation and financial impact of Rule 49. Jt. Ex. 38.

g. Subsequent to its April 29 submission and in response to further HHS requests, the State orally submitted additional data regarding, primarily, the regional maximum limitation.

i. This additional data identified those facilities which were hospital-based, the fiscal year-end of the facilities which had rates limited by the regional maximum limitation, the nursing home occupancy level of those facilities which had costs disallowed by the regional maximum limitation, the Medicaid occupancy for these same facilities and a breakdown of the costs of facilities which had costs disallowed by the regional maximum.

7. HHS' review of the data submitted by the parties was detailed and comprehensive.

a. The four HHS officials involved in the review and verification of Rule 49 spent in excess of 300 hours reviewing the Rule and the submissions of the State and MAHCF.

b. The ultimate decision-maker and the author of the HHS Report, Robert Streimer, Director of Alternative Reimbursement Systems in the Bureau of Program Policy of the Health Care Financing Administration of HHS, reviewed the documents submitted by MAHCF as well as those submitted by the State.

c. Mr. Lyman, a principal analyst of the data submitted by the State and MAHCF thoroughly reviewed the data and comments submitted by MAHCF.

8. Rule 49 complied with federal law by providing reimbursement on a reasonable cost-related basis prior to October 1, 1980.

a. Rule 49 was approved and verified by HHS as in compliance with federal law both prior to and after October 1, 1980.

b. The MSRI Study establishes, at best, that Rule 49 disallows certain costs in determining the basis of the rates for the next year and does not suggest that the actual costs of nursing homes are not reimbursed for any given year. Therefore, it does not establish that Rule 49 is not reasonable cost-related. Ps' exs. 1 and 20.

c. One of plaintiffs' chief witness, Mr. Richard Kahan, admits that his definitions of terms and concepts, including reasonable cost-relatedness, are inconsistent with those applied by the Department of Health and Human Services, the agency charged with interpreting and implementing the relevant statutes and regulations.

d. Mr. Kahan admits that his definition of the term "reasonable cost-related" does not comport with that applied by Judge Devitt throughout this litigation.

e. The Deloitte Study, defendants' exhibit 1a and 1b, found that, of the homes in the samples, 99.29% and 99.41% of the nursing home expenses attributable to Medicaid were reimbursed by Rule 49 in 1976 and 1979, respectively.

9. In determining compliance with federal law, Rule 49 must be viewed as a whole. Jt. Ex. 32. Nevertheless, each of its internal limitations is acceptable under federal law.

a. Depreciable asset basis limitation.

i. HHS verified that the Rule 49 depreciable asset basis limitation (investment per bed limitation) complies with federal law. Jt. Ex. 32, p. 2-3.

ii. The depreciable asset basis limitation of Rule 49 is derived from data taken from actual construction costs compiled and supplied by the Minnesota Health Department for a 6-year period, 1967-1972. It has been annually adjusted since January 1, 1974, on the basis of a Department of Commerce Construction cost index composite. Jt. Ex. 32, p. 2-3.

iii. The Department of Commerce construction cost index is a generally accepted measure of construction cost increases. Jt. Ex. 32, p. 3

iv. The base amount of the limitation and the subsequent adjusted limitations reasonably correlate to the construction costs which an efficiently and economically operated facility could expect to incur in building a new facility or adding beds to a facility. Jt. Ex. 32, p. 3

v. Fifteen of the 437 facilities in Minnesota had costs disallowed by the limitation.

vi. The MSRI Study, submitted by MAHCF to HHS, revealed that only 3%, or at most 15 of the 440 cost reports considered, had costs disallowed by the depreciable asset basis limitation. Ps' Ex. 1, Appendix II.

vii. The amended MSRI Study submitted to the court indicates that only 14 of the 426 cost reports, or 3%, of the sample were subjected to the depreciable asset basis limitation. Ps' Ex. 20, Variable 13.

viii. As to the few facilities with costs disallowed by this limitation, plaintiffs offered no evidence to establish that the disallowed costs resulted from inadequate reimbursement under Rule 49 rather than from unreasonable construction costs relating from the owners personal preferences in construction features. No evidence was offered to establish that these facilities were efficiently and economically operated.

ix. Plaintiffs' witness, Mr. Richard Kahan, admitted that he had not reviewed any data or performed any calculations to determine whether or not the annual cost indexing in fact tracked construction cost changes.

b. Interest expense and investment allowance.

i. HHS verified that the interest expense limitation and the investment allowance for proprietary nursing homes comply with federal law. Jt. Ex. 32, p. 4-5.

ii. Payment of interest expense and investment allowance by Rule 49 provides an opportunity for profit even though the payment of profit is not required by federal law. Jt. Ex. 32, p. 5.

iii. Although, low-cost financing alternatives are available to nursing home owners, witness Kahan admitted that he had no knowledge of these financing alternatives.

iv. A number of sales of nursing homes were negotiated in 1981. In only one transaction was the interest rate, either on the contract for deed or promissory note, above 12% and that rate was 13% after September 30, 1985. D. Ex. 18.

c. Top management compensation.

i. HHS verified that the top management compensation limitation complies with federal law. Jt. Ex. 32, p. 6.

ii. The data base of compensation levels for top management in county-operated facilities and the annual inflation adjustment tied to the Consumer Price Index are reasonable. Jt. Ex. 32, p. 6

iii. The MSRI Study commissioned by MAHCF indicates that only 5% or 22 of the 440 cost reports had compensation disallowed by the top management compensation limitation. P. Ex, 1, Appendix VII.

iv. The revised MSRI Study submitted to the court indicates that only 6% or 24 of the 426 cost reports had compensation denied by the top management compensation limitation. P. Ex. 20, Appendix VII, Variable 12.

v. Data submitted by the State of Minnesota to HHS indicated that in 1978 13% or 52 of 389 facilities had compensation denied by the top management compensation limitation. Jt. Ex. 32, p. 6; Jt. Ex. 38, Supp. No. 3, p. 12.

vi. Data submitted by the State of Minnesota to HSS indicated that in 1979 15% or 58 of 397 facilities had compensation denied by the top management compensation limitation. Jt. Ex. 32, p. 6; Jt. Ex., supp. No. 3, p. 12; and testimony of Rau, V. 3, p. 37-38.

vii. The $35,000 top management compensation limitation was approved initially by HHS in 1978 and, even after accounting for inflation, remains a reasonable ceiling figure. Jt. Ex. 32, p. 6.

viii. Plaintiffs' witness, Mr. Richard Kahan, testified that "reasonable costs" are the amount a prudent buyer would expend in an arm's-length transaction. Testimony of Kahan, p. 38-39. In a survey of 39 facilities conducted by plaintiffs' accountant witness, Mr. Jack Brose, 15 had management compensations set pursuant to arm's-length agreements. *None* of these 15 had costs disallowed by the top management compensation limitation. P. Ex. 22. Of the remaining 24 facilities where owners set their own salaries, 19 had costs disallowed by the limitation. *Id.*.

d. The lesser care limitation.

i. HHS verified that the lesser care limitation complies with federal law. Jt. Ex. 32, p. 7-8.

ii. The data supplied HHS by the State of Minnesota support the 85% per diem limits for the lesser care levels. Jt. Ex. 32, p. 7. For example, data from the urban regions of the State indicate that costs for providing intermediate level care were 85.8% of the costs required to provide skilled care. Jt. Ex. 35.

iii. Data submitted to HHS by the State indicate that the actual rates paid for the skilled and intermediate levels of care parallel the percentage factor limits of the lesser care limitation. Jt. Ex. 32, p. 7. For example, the data indicate that intermediate care level rates for proprietary facilities are 83% of proprietary skilled rates and that intermediate care level rates for non-profit facilities are 79% of non-profit skilled rates in the State of Minnesota. Jt. Ex. 32, p. 7; Jt. Ex. 38.

e. Raw food cost formula.

i. HHS verified that the raw food cost formula of Rule 49 complies with federal law. Jt. Ex. 32, p. 9-10.

ii. The raw food cost allowance reasonably takes into account actual costs and economic trends. Jt. Ex. 32, p. 9-10.

iii. The approximate per diem raw food cost of all nursing facilities in the State of Minnesota was $1.20 at the time Rule 49 was adopted. Jt. Ex. 32, p. 9.

iv. In that the raw food cost allowance is calculated by adding an inflation factor to the actual costs incurred for raw food by a particular faciality the preceding year, any discrepancy between the allowance and actual raw food cost increases is self-correcting because the discrepancy from the preceding year would be absorbed into the facility's actual historical costs for raw food and therefore would be reflected in its raw food reimbursement.

f. Unidentified cost changes.

i. HHS verfied that Rule 49's reimbursement of unidentified cost changes complies with federal law. Jt. Ex. 32, p. 10-13.

ii. Unidentified costs comprise only 15% to 20% of the total allowable costs of a facility. Jt. ex. 32, p. 11.

iii. Unidentified costs are an aggregate of a variety of allowable costs such as nursing and other supplies and professional services. They are adjusted or updated for inflation based on the rate of increase in the Consumer Price Index. Jt. Ex. 32, Ex. A, p. 3.

iv. The Consumer Price Index aggregates the inflation rates of a variety of costs and is an appropriate index for unidentified cost changes.

g. Maximum rate limitation.

i. HHS verified that the maximum rate limitation of Rule 49 complies with federal law. Jt. Ex. 32, p. 14-18.

ii. The Medicaid Act permits state plans to employ broad classifications based on geography, type of home and other reasonable distinctions in determining compensation.

iii. Since broad classification for reimbursement may not provide adequate compensation in specific instances, it appears possible and permissible for some homes not to be reimbursed for their full actual allowable reasonable costs even if efficiently operated.

iv. In part, the regional maximum limitation operationally defines efficiently and economically operated facilities. Jt. Ex. 32, p. 16, 18.

v. An annual survey of each of the approximately 440 nursing facilities in the State of Minnesota to determine whether each facility is economically and efficiently operated would be cost-prohibitive and practicallly infeasible.

vi. The regional maximum limitation establishes a prospective rate within which facilities can reasonably be expected to operate if efficiently and economically operated.

vii. Over 90% or 509 of the 564 facilities were able to operate within their prospectively established rates and had no reasonable allowable costs disallowed by the regional maximum limitation in 1979. Jt. Ex. 32, p. 17.

viii. Among the facilities having reasonable allowable costs disallowed by the regional maximum limitation, there is an absence of any pattern in the costs and characteristics of those facilities. Jt. Ex. 32, p. 18.

ix. The facilities which had costs disallowed by the regional maximum limitation had excess costs in one or more internal cost centers but the particular cost centers varied from facility to facility. Jt. Ex. 32, p. 18.

x. The inability of some facilities to live within the rate established by Rule 49 resulted from factors outside the Rule such as inefficiency, low occupancy and withdrawal from participation in the Medicaid program. Jt. Ex. 32, p. 18.

h. Nursing hour limitation.

i. HHS verified that the nursing hour limitation of Rule 49 complies with federal law. Jt. Ex. 32, p. 19

ii. The MSRI Study prepared for MAHCF indicates that only 2% or 8 of the 426 cost reports examined had costs disallowed by the nursing hours limitation. P. Ex. 20, Appendix VII, Variable 11.

10. Rule 49 complies with the reimbursement standards established by Section 962 of the Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499 ("Boren Amendment").

a. No party to this litigation contends that the Boren Amendment increases the level of reimbursement required by the reasonable cost-related standard in order to satisfy federal law.

b. Inasmuch as Rule 49 meets the reimbursement standards required by the at least equally strict reasonably cost-related standard, Rule 49 satisfies the standard of the Boren Amendment.

c. Rule 49 provides for reimbursement to providers of long-term care services at rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facialities.

d. HHS has approved and verified Rule 49 for compliance with the Boren Amendment. HHS Report, Jt. Ex. 32, p. 20.

CONCLUSIONS OF LAW

1. The court has jurisdiction. 28 U.S.C. §1331, 2201, 2202.

2. The parties have voluntarily consented to the disposition of this matter before the undersigned and that consent has been approved by the District Court. Clerks Entry 221, 28 U.S.C. §636(c).

3. Participation in the Medicaid Program by nursing homes in Minnesota is voluntary.

4. The rates established by Rule 49 are adequate and comply with the requirements of federal law.

5. The implementation of Minn. Stat. 256B.48 does not violate the Due Process Clauses of the Constitutions of the United States and the State of Minnesota.

6. The enforcement of Minn. Stat. 256B.48 does not violate the Equal Protection Clauses of the Constitutions of the United States or the State of Minnesota.

7. The enforcement of Minn. Stat. 256B.48 does not impair the obligation of contracts.

8. Minn. Stat. 256B.48 is not unconstitutionally vague.

9. Minn. Stat. 256B.48 is not an illegal condition on Medicaid participation.

10. HHS approval is not a condition precedent to the implementation or enforcement of Minn. Stat. 256B.48.

11. The Minnesota Medicaid Reimbursement System does not violate due process rights of plaintiffs.

12. The Minnesota Medicaid Reimbursement System provided reimbursement

a. On a reasonable cost-related basis at all times prior to October 1, 1980;

b. At rates which were reasonable and adequate to meet the costs incurred by efficiently and economically run nursing homes thereafter.

13. HHS reviewed and verified the Minnesota Medicaid Reimbursement System as required by statute and the orders of the District Court in this litigation.

14. Any Finding of Fact which should have been labeled as a Conclusion of Law is hereby designated as a Conclusion of Law.

DATED: 26 April, 1983.

BRIAN P. SHORT
United States Magistrate

United States District Court

DISTRICT OF MINNESOTA
THIRD DIVISION

MEMORANDUM

Civil 3-77-467

Minnesota Association of Health Care Facilities, Inc.; Sunshine Villa, Inc.; Augustana Lutheran Homes, Inc.; Red Wing Nursing Home of TLC Nursing Centers, Inc.; Mala Strana Nursing Home of New Prague,

Plaintiffs,

and

Excelsior Nursing Home, of Iroquois-Excelsior, Inc.; and Valleyview Nursing Home, Inc.;

Plaintiff-Intervenors,

v.

Minnesota Department of Public Welfare; Arthur E. Noot, Commissioner of Public Welfare,

Defendants.

and

Nursing Home Residents' Advisory Council,

Defendant-Intervenor.

Civil 3-78-88 *

Minnesota Hospital Association; Canby Community Hospital and C & NC Unit District No. 1; Divine Providence Hospital and Home, Inc.; Good Shepherd Lutheran Home of Sauk Rapids, Minnesota; Guardian Angels Foundation of Elk River, *

Plaintiffs, *

v. *

Minnesota Department of Public Welfare and Arthur E. Noot, Commissioner of Public Welfare, *

Defendants. *

JOHN M. BROEKER, Esq. and STEVE M. MIHALCHICK, Esq., BROEKER, HARTFELDT, HEDGES & GRANT, for plaintiffs and plaintiff-intervenors.

LAURIE N. DAVISON, Esq., LEGAL AID SOCIETY OF MINNEAPOLIS, INC., for defendant-intervenor.

WILLIAM P. MARSHALL, Esq. and BRAD P. ENGDAHL, Esq., Special Assistant Attorney Generals, for defendants.

MICHAEL J. PHILIPP, Esq., HAMILTON & PHILIPP, for plaintiff Minnesota Hospital Association.

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I. INTRODUCTION

This challenge to the Minnesota Medicaid Reimbursement System was tried before the undersigned with the consent of the parties as authorized by 28 U.S.C. §636. Evidence was received over several weeks, hundreds of pages of post-trial briefs were submitted and the parties presented final arguments at the close of the briefing schedule. The court has now had an opportunity to study those briefs in some detail and to review the hundreds of trial exhibits received into evidence. Based on that review, and upon all of the evidence presented at trial, the court has today issued Findings of Fact and Conclusions of Law, this memorandum opinion and an order directing the Clerk's Office to enter judgment on behalf of defendants.

This case is very important for the parties. in their brief, plaintiffs and plaintiff-intervenors Minnesota Association of Health Care Facilities, Inc., and some of its members (hereinafter "MAHCF plaintiffs" or "MAHCF") suggested that "the issue in this litigation may well resolve itself down to simply whether the long term care industry, as we know it day, can survive" Brief of Plaintiffs and Plaintiff-Intervenors at 1. While defendants, with equal vigor, suggest that ultimately, what is involved here is "the ability of the State to be the architect of its own reimbursement methodology under the Medicaid Program." Defendants' Post-Trial Memorandum at 17.

The care with which the parties presented the evidence at trial and crafted the post-trial briefs clearly demonstrates the importance of this litigation.

In their briefs, the parties recite with some precision, the procedural history of this c[illegible] It would not serve any purpose to further comment on that history, except to observe that this case seems to have a life of its own.

II. SUMMARY OF PLAINTIFFS' CLAIMS

A. Introduction

MAHCF challenges the validity of the Equalization Statue Minn. Stat. 256B.48[1] on statutory and constitutional grounds and the statutory adequacy of the Minnesota Medicaid Reimbursement System for long term health care providers (Rule 49). Plaintiff Minnesota Hospital Association (MHA) challenges only retroactive payback provision of the Equalization Statute. These lawsuits were tried together and this Memorandum and the Findings of Fact and Conclusions of Law filed today relate to both lawsuits.

The Department of Public Welfare and its Commissioner (defendants) contend that plaintiffs' challenges to both the Equalization Statute and Rule 49 are spurious and should be dismissed out of hand. Defendant-intervenors limit their argument to the challenge to the Equalization Statute. However, they concur with the State in its analysis of the rest of plaintiffs' claims.

For discussion purposes, it seems best to briefly summarize each of plaintiffs' challenges. In the Sections III and IV those challenges will be analyzed in greater detail in light of the evidence presented and the legal arguments presented by defendants.

B. Plaintiff's Challenges to the Equalization Statute.

1. The Statute

Minn. Stat. §256B.48, subd. 1(a) provides:

No nursing home shall be eligible to receive medical assistance payments unless it agrees in writing that it will refrain from:

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[1]This statute is also referred to as the Private Pay Law in this Memorandum and the court's Findings of Fact and Conclusions of Law.

(a) Charging nonmedical assistance residents rates for similar services which exceed by more than ten percent those rates which are approved by the state agency for medical assistance recipients. For nursing homes charging nonmedical assistance residents rates less than ten percent more than those rates which are approved by the state agency for medical assistance recipients, the maximum differential in rates between nonmedical assistance residents and medical assistance recipients shall not exceed that differential which was in effect on April 13, 1976. If a nursing home has exceeded this differential since April 13, 1976, it shall return the amount collected in excess of the allowable differential stated by this subdivision to the nonmedical assistance resident, or that person's representative, by July 1, 1977.

This statute was originally enacted by the Legislature in 1976. In 1977, the Legislature amended the statute by adding the portion underlined above. This 1977 addition is referred to as the "retroactive payback provision" and will be discussed below. The law as it was before this 1977 amendment is called the "Private Pay Law" or the "Equalization" Statute. Plaintiffs challenge the statute on a number of bases.

2. The Private Pay Law and the implementation thereof violates the due process claim of the Constitutions of the United States and the State of Minnesota.

Relying on *Bluefield Co. v. Pub. Serv. Comm.*, 262 U.S. 679 (1923), plaintiffs content that the implementation of this law constitutes a "taking" of property without just compensation.

3. The Private Pay law and the enforcement thereof violates the equal protection clauses of the United States and the State of Minnesota.

Plaintiffs claim that because the Private Pay Law applies, by its terms, only to nursing homes and not to all other health care providers, it is arbitrary and invidiously discriminates against them.

4. The Private Pay Law and the enforcement thereof unconstitutionally impair the obligation of contracts.

This contention has two prongs. First, the legislation affects the rights plaintiffs have in the contracts they have with private pay patients. Second, the legislation affects the "contract" plaintiffs had with the State concerning the provision nursing home services to the general public.

C. Plaintiffs' challenges to the Minnesota Medicaid Reimbursement System (Rule 49).

The statutory and regulatory framework which established and controls the Minnesota Medicaid Reimbursement System is discussed in detail by the parties in their post-trial memoranda (e.g. Defendants' Post-Trial Memorandum at p. 7 *et. seq.*). The subject is very complex and no discussion of it can be brief. Thus, because the briefs of the parties address the subject comprehensively and any further discussion would only add to the length of this memorandum, the court will not review in any detail the reimbursement system established in Minnesota and challenged in this Memorandum.

However, Title XIX of the Social Security Act established the Medicaid Program to provide, on a state-federal cooperative basis, medical services to low income individuals. Federal law requires participating states to establish a system designed to reimburse those providing medical services to eligible individuals. The Minnesota Department of Public Welfare has established such a reimbursement system by rules promulgated according to Minnesota law. (Rule 49).

During the course of this litigation the federal statute which governed that reimbursement system has been modified. Section 249 (codified at 42 U.S.C. §1396a(a)(13)(E) (i972) required the state reimbursement system to pay for skilled nursing and intermediate care nursing services on a "reasonable cost related basis." That provision of the law was modified by the Boren Amendment (Section 962 of the Omnibus Reconciliation Act of 1980 P.L. 96-499). Effective October 1, 1980, the reimbursement system had to pay for nursing services at rates which were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities."

Although there is some dispute as to whether the Boren Amendment changed the requirements of federal law, plaintiffs maintain that the reimbursement provided under Rule 49 is inadequate and does not satisfy either standard.

Further, federal regulations require the Secretary of HHS (formerly HEW) to "verify" that the reimbursement system was "reasonably cost related" until October 1, 1980, and "reasonable and adequate" thereafter. At the specific direction of the District Court (October 15, 1980, and "reasonable and adequate" thereafter. At the specific direction of the District Court (October 15, 1980 order), HHS was required to verify the state plan. Although HHS examined the state plan — conducted an investigation of its application and issued a report — Joint exhibit 32, plaintiffs content that the statutory verification requirement and the court's order have not been satisfied. *Inter alia*, plaintiffs contend that the scope of the plan review was not broad enough, and much of the material considered by HHS was inaccurate or incomplete.

D. Miscellaneous Challenges

1. The Private Pay Law imposes an illegal condition on medical assistance participation in violation of federal law.

Plaintiffs point out that federal law does not allow the states to impose additional eligibility requirements which would exclude individuals, eligible under federal law, from medical assistance (Medicaid) participation. Plaintiffs contend that the private pay law, which requires nursing homes to charge private pay residents the same rate as is charged MA residents, is an additional, unauthorized *condition of participation* in the MA program, and therefore violates this federal law.

2. Defendants failed to obtain prior federal approval of the Private Pay Law.

Federal law requires that the state plan be submitted to HHS for review when substantial changes are made in it by changes in applicable state law or regulation. The Private Pay Law, a significant change to the state plan, was never submitted to HHS for review prior to implementation.

E. Conclusion

Plaintiffs have challenged, on substantive and procedural grounds, the Equalization Statute and the Minnesota Reimbursement System. Plaintiffs contend that the enforcement and implementation of those state law provisions are in violation of federal law and their constitutional rights. This gives rise to a cause of action under the Civil Rights Act of 1871, 42 U.S.C. §1983 and justifies an award of attorneys' fees under 42 U.S.C. §1988. Each of these claims will be discussed and analyzed in some detail in Sections III and IV.

III. PLAINTIFFS' CHALLENGES TO THE EQUALIZATION STATUTE

Plaintiffs maintain that the Equalization, both alone and in conjunction with Rule 49, violates a number of provisions of the Constitutions of the State of Minnesota and of the United States. In addition, it is an unauthorized condition, imposed by the State, restricting participation in the Medicaid Program which has not been adequately reviewed by HHS, all in violation of Federal Statute and Regulation. Each of these challenges will be discussed below.

A. The Constitutional Challenges

1. The Private Pay Law and its implementation violate the due process clauses of the Constitutions of the United States and the State of Minnesota.

Plaintiffs concede that the State has authority to regulate the Medicaid Reimbursement System. However, they contend that the implementation of the Equalization State, when coupled with the inadequate Medicaid reimbursement rate provided under Rule 49 results in a deprivation of plaintiffs property without due process of law. Essentially, plaintiffs contend that this constitutes a taking or private property without just compensation.

Defendants' initial response to this contention, as it is to all of plaintiffs' constitutional challenges, is that provider participation in the Medicaid Program is voluntary and thus the due process rights which plaintiffs claim have been violated do not even attach.

Relying heavily on *Bluefield Co. v. Pub. Serv. Comm.*, 262 U.S. 679 (1923), plaintiffs contend that they are entitled to revenues which yield a "reasonable return on the value of the property used. . . ." *Id.* at 690. Further, plaintiffs contend that "any rate insufficient to constitute a reasonable return on the value of the property used and services rendered is confiscatory." Brief of Plaintiffs and Plaintiff-intervenors at 24.

Admitting that the standard under the Medicaid Act does not require a reimbursement rate that covers "all legitimate expenses," *id.* at 25, plaintiffs complain that unless they are allowed to "subsidize" Medicaid patients with the private pay patients, they will not survive as viable economic units. Thus, the implementation of the rate Equalization Statute is confiscatory and deprives plaintiffs of their property in violation of the due process standards announced in *Bluefield* and the other cases cited at pp. 23-24 of Plaintiffs' Post-Trial Brief.

In summary, plaintiffs will concede, for the purposes of this argument, that the Medicaid Act does not require a constitutional rate of reimbursement. However, when the State deprives them of the opportunity to raise the overall rate of return to a constitutional level, by prohibiting the subsidization of the Medicaid patients with the revenues received from private pay patients, an unconstitutional taking occurs.

Of course, the "voluntariness" defense is appealing because it is straight forward, simple, and dispositive of all of the constitutional challenges made in this case. However, plaintiffs contend that participation in the Medicaid Program is not in fact voluntary.

First, the evidence produced at trial established that approximately 60 percent of all nursing home patients in Minnesota are Medicaid recipients. Thus, in order to stay in business, plaintiffs must be able to accept Medicaid patients.

Second, plaintiffs testified through their owners, executives, and administrators that they have a moral obligation to provide care and services to all in the community in need of that care and service, regardless of the individual's ability to pay.

In conclusion, plaintiffs contend that the voluntariness defense is without basis in fact. They must participate in the Medicaid Program — both from an economic and moral point of view — and consequently accept the limitations imposed by the Equalization Statute in order to survive.

Accepting that as true — i.e. in order to survive as a nursing home organization, plaintiffs must accept Medicaid patients — plaintiffs' participation in the Medicaid Program is nonetheless "voluntary" for due process analysis. *Minn. Ass'n of Health Care Facilities, etc. v. Minn. Dept. Pub. Welfare*, 602 F.2d 150, 153-54 (8th Cir. 1979).

The decision of the Court of Appeals relied on above is that court's opinion affirming the District Court's denial of plaintiffs' application for a preliminary injunction in this case. The court clearly states that its opinion is not to be considered controlling on the issues presented for resolution. *Id.* at 155. Nevertheless, the court's analysis is persuasive, in fact compelling: participation in the Medicaid Program is voluntary because, if plaintiffs "find that the reimbursement rates are insufficient, then they may either make their homes more efficient and economical or terminate their relationship with Medicaid and no longer accept Medicaid recipients as residents. [citations omitted]. Moreover, '[a] nursing facilit[y's] [economic] 'need' for patients has nothing to do with the statutory benefits structure. The facility's need is incidental. That a particular nursing facility was certainly not Congress' foremost consideration in its creation of the Medicaid Program.'" *Id.* at 154.

It is true that the Court of Appeals reached its decision before all of the evidence was presented at trial.[2] There is no question but that the evidence establishes that plaintiffs' financial interest compels participation in the Medicaid Program. Further, many of the individuals who operate nursing homes are compelled because of their sense of duty, to provide nursing home services to all, regardless of ability to pay. While this sense of duty is admirable, it does not make participation in the Medicaid Program any the less voluntary.

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[2]Although there was substantial evidence presented at the injunction hearings, including the affidavit of witness Kahan, and this evidence was part of the record considered by the Court of Appeals.

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In conclusion, because participation in the Medicaid Program is voluntary, it cannot be maintained that application of the Equalization Statute, either alone or in conjunction with Rule 49, violates the due process provisions of the State or Federal Constitutions.

Even if it is accepted that participation in the Medicaid is not in fact voluntary, and that due process analysis applies, plaintiffs' challenge nonetheless fails. They have not established a violation of substantive due process standards.

Bluefield, to the extent it is applicable, seems to indicate that the rate paid must be such as to permit a return equal to that generally earned by others in the same business. Plaintiffs suggest that the Medicaid rate paid under Rule 49 is inadequate under *Bluefield*. If they are unable to subsidize this Medicaid side of their business by, in effect, "overcharging"[3] their private pay patients, their entire rate of return would be inadequate under *Bluefield*.

Because the state uses "prospective" rate setting procedures, there never should be a problem with inadequate reimbursement. In other words, if a provider knows that only certain services will be reimbursed and at a specific level, *in advance* of the year in which the services are actually provided to the residents, it can budget and take certain other actions in reliance on that prospectively set rate. Plaintiffs seem to accept this. Reply Brief of Plaintiffs and Plaintiff-Intervenors at p. 2.

However, despite the fact that defendants refer to this as a prospective rate setting mechanism, the evidence disclosed that most providers do not know what their Rule 49 reimbursement rate is until the year is almost half over. Often the reimbursement rate is not final until the year is over. Nevertheless, the due process argument fails: Plaintiffs have not established by a preponderance of the evidence presented at trial that the overall rate — i.e. the Medicaid reimbursement rate and the private pay rate as limited by the Equalization Statute — was constitutionally impermissible.

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[3]That is charging that these private pay patients more than plaintiffs would deem required in light of the goods and services provided, expected profit level and competitive pressures.

Plaintiffs maintain that they have a *right* to subsidize the allegedly inadequate Rule 49 reimbursement rate by overcharging the private pay patients. In its decision mentioned above, the Court of Appeals had an opportunity consider this issue and said

> [w]e are not persuaded that [plaintiffs] had any such right, as Medicaid providers, to charge private patients higher rates in order to recoup the losses sustained as a result of the allegedly inadequate reimbursement rates paid by the State for Medicaid patients.

Id. at 154.

Thus, because they do not have the right to subsidize the rates, the due process claim fails. However, even assuming that plaintiffs have the "right" to subsidize the Medicaid rates with private pay rates, the "right" must be balanced against other rights present here and analyzed in light of the evidence presented.

First, the Equalization Statute is a piece of economic legislation and enjoys the presumption of constitutionality. *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976). Second, plaintiffs must establish that the actual overall rate received is too low, by clear and convincing evidence. *FPC v. Texaco, Inc.*, 417 U.S. 380 (1974).

As is mentioned above, the *Bluefield* test, advocated by plaintiffs, is a comparative one: is the rate at issue comparable to that earned on similar investments giving proper regard to geography, business risk, etc. No evidence was presented which would establish that the overall rate of return earned in plaintiffs' industry was not comparable to rates earned in other industries or on other investments with comparable business risk factors.

However, plaintiffs suggest that because "all legitimate expenses" are not reimbursed by the Minnesota Reimbursement System, the system is confiscatory and deprives plaintiffs of their property without due process of law.

Plaintiffs principally rely on the Deloitte Study, Ds' ex. 1, and the MSRI Study, Ps' ex. 1, for the evidence to support this contention. Brief of Plaintiffs and Plaintiff-Intervenors at 25- 26.

Both exhibits purportedly show that many expenses of the industry go unreimbursed and that the industry is not a profitable one.

It is interesting to compare the parties' analysis of these two exhibits. See Brief of Plaintiffs and Plaintiff-Intervenors at 25-29 and Defendants' Post Trial Memorandum at 62-67. Both sides contend that the statistical data in those studies support their positions.

What those studies show is that some providers are profitable, some are not; some providers receive reimbursement for all of their expenses, some do not. This kind of evidence is hardly the stuff of which a compelling due process claim is made. One need merely to read the business section of any newspaper to know that some business operators and profitable and some are not. Those which are tend to survive; those which are not, do not.

In conclusion, plaintiffs have not established by clear and convincing evidence that the regulatory scheme at issue here — the implementation of the Equalization Statute — produces confiscatory rates of reimbursement thus working an unconstitutional taking of property. What is clear is that the State is vigorously regulating the industry and that those in the industry do not like it. However, to say that this is a violation of the due process clause would be to trivialize the Constitution.

2. The Private Pay Law and the enforcement thereof violates the Equal Protection Clauses of the Constitutions of the United States and the State of Minnesota.

Plaintiffs contend that the Private Pay Law fails to pass Equal Protection muster because it

–invidiously discriminates against nursing homes;
–is totally arbitrary; and
–is not rationally related to legitimate State purposes.

Brief at 30.

By its terms, the Private Pay Law applies only to nursing homes. Plaintiffs maintain that nursing homes should be treated as other classes of Medicaid providers — *e.g.* facilities for the mentally retarded, hospitals and boarding care homes, pharmacies and laboratories — are treated. Because these other providers do not have to cope with the Equalization Statute, nursing homes suffer discriminatory treatment.

Whether the classification drawn by the legislature passes constitutional muster is determined by reference to the rational basis test. *City of New Orleans v. Dukes*, 427 U.S. 297 (1976). That is, this legislative classification may not be questioned by the court unless plaintiffs can establish that there is no reasonable or rational basis for it.

The evidence established that nursing homes provide, on a continuing basis, health care services to those they serve. Hospitals, pharmacies and laboratories do not provide care on this basis. Thus, the legislature classification is justified in fact because of the difference in the level and kind of care provided.

The distinction drawn by the legislature between nursing homes and other long term residential health care facilities, such as boarding care facilities and facilities for the mentally retarded, is not supportable on this basis. However, the evidence presented did establish that there were differences in the levels of care offered at these types of facilities and of nursing homes. In addition, there is evidence which distinguishes the categories of facility on the basis of occupancy rate and licensure standards. Under the *Dukes* rational basis test this is enough to justify the classification.

In conclusion, the Private Pay Law does not invidiously discriminate against plaintiffs; the classifications drawn by the legislature in connection with its passage are not arbitrary but are rationally related to the legitimate State purposes.

3. The Private Pay Law and the enforcement thereof unconstitutionally impairs the obligation of contracts.

In order to fully understand this claim, a brief factual introduction is necessary. Plaintiffs contend that this piece of legislation is unconstitutional because it alters the obligations of existing contracts and because it deprives them of anticipated benefits of those contracts without just compensation.

Plaintiffs contend that the Private Pay Law and the retroactive pay back provision affects not only the contracts between the providers and private pay patients but also the contracts, created by the regulatory scheme, between the State and the providers. *U.S. Trust Co. v. New Jersey*, 431 U.S. 1 (1977), *State of Indiana ex rel. Anderson v. Brand*, 303 U.S. 95 (1938). In other words, because the Equalization Statute Limits the amount plaintiffs can charge their private patients and the retroactive pay back provision required them to refund some money, the contracts between the providers and private pay patients were obviously affected. In addition, prior to the passage of the Private Pay Law, the regulatory condition of the industry was such that no legal limits were placed on the amounts private pay patients could be charged. This absence of limiting regulation set conditions for participation in the M.A. Program and, having met those conditions, providers had a "right" to participate in the program. Taking it one step farther, passage of the Equalization Statute specifically authorized plaintiffs to charge their private pay patients up to 10 percent more than the M.A. rate. In reliance upon that state of the regulatory scheme, plaintiff entered into a number of contracts with private pay patients. The contract between the State and providers was simple: the regulatory scheme would remain more or less, as it was, the plaintiffs would provide nursing home services. The retroactive payback provision altered the rules.

Of course, the only enforcement mechanism available to the state is continued participation in the M.A. Program: if a provider does not care to comply with the terms of the Private Pay Law and the retroactive payback provision, it is not eligible to participate in the M.A. Program.

The discussion of the "voluntariness" issue above obviously controls here. A provider contract with its private pay patients need not be affected by the Private Pay law if the provider elects to withdraw from the Medicaid Program.

However, even assuming that participation in the M.A. Program is not voluntary, the Private Pay Law easily survives plaintiffs' contract clause challenge.

Not only is the Private Pay Law a reasonable exercise of the State's police powers — the State has a duty to protect those in need of nursing home services — obviously a group which the legislature could reasonably conclude was desperately in need of protection — but also plaintiff are in a heavily regulated industry and could have foreseen — and in fact did foresee — this legislation. Thus, on the merits, plaintiffs contract clause challenge fails. *Allied Structural Steel v. Spannaus*, 438 U.S. 234 (1978).

4. The Retroactive Refund Statute is void because of vagueness.

Plaintiffs in the Minnesota Hospital Association case contend that the pay back provision is unconstitutionally vague *inter alia* because the legislature failed to define what it meant by the phrase "differential in effect on April 13, 1976." They do not know whether the legislature meant a percentage differential or a dollar differential.

In order to succeed on this challenge, MHA must make a rather substantial showing: it must establish that the statute is so vague that those subject to it must guess at its meaning. *Connally v. General Construction Co.*, 269 U.S. 385 (1926). The statue itself is couched in terms of a percentage ("more than ten percent . . .") and the administrative interpretation of the statute by Mr. Rau, the State official responsible for the MA Program, follows suit.

MHA claims the statute is vague in a number of other particulars. It is the court's conclusion that it has failed on each one. Given the legal standard to be applied — the heavy burden imposed on plaintiff and the presumption of constitutionality to be afforded the statute, it is clear that this challenge fails.

B. The Statutory Challenges

1. The Private Pay Law imposes an illegal condition on medical assistance participation.

Plaintiffs point out that, by its terms, compliance with the Private Pay Law is a condition of provider participation in the Medical Assistance Program. Because the federal law does not require rate equalization this compliance with the Private Pay Law is an illegal additional condition.

In addition, plaintiffs contend that states may not impose additional eligibility requirements the effect of which are to exclude persons otherwise eligible for medical assistance. Plaintiffs contend that the enforcement of the Equalization Statute is "not legally distinguishable from the imposition of an additional condition of participation upon the recipients who reside in the nursing homes." Brief of Plaintiffs and Plaintiff-Intervenors at 79.

States may in fact regulate and administer the Medical Assistance Programs. *Michael Reese Physicians & Surgeons, S.C. v. Quern*, 606 F.2d 732 (7th Cir. 1979). This case squarely meets these contentions.

2. Defendants' failure to obtain prior federal approval of the Private Pay Law violates federal law.

Plaintiffs, and Amicus American Health Care Association, contend that the Equalization Statute works a substantial change to Minnesota State Plan and that consequently, prior to implementation, the Plan and the Statute must be submitted to HHS for review and approval.

Because the Equalization Statute was never submitted to HHS and that agency never reviewed it, plaintiffs contend that 42 U.S.C. §1396a(b) has been violated. That Statute requires the Secretary to review all state plans for compliance with the conditions established by §1396a(a).

At an earlier stage in this litigation, plaintiffs demanded that the Equalization Statute be submitted to HHS for review. That demand was rejected by Judge Devitt in his order dated December 24, 1980, Clerk's Entry No. 217. The Equalization Statute does not have an effect on the level or extent of reimbursement under the State Reimbursement Plan. Consequently, it cannot be said to affect or be a part of the State Plan. It thus does not have to be reviewed by HHS.

IV. PLAINTIFFS' CHALLENGES TO THE MINNESOTA MEDICAID REIMBURSEMENT SYSTEM

A. Constitutional Challenge

At least by implication, plaintiffs contend that the rates paid by the State pursuant to the Minnesota Medicaid Plan for reimbursement are so low as to be confiscatory, depriving plaintiffs of property without due process of law. Brief of Plaintiffs and Plaintiff-Intervenors at 23. This contention has been treated adequately, *supra* III A 1.

B. The Statutory Challenges

1. The Minnesota Reimbursement System did not pay for skilled nursing and intermediate care nursing services on a reasonable cost-related basis from July 1, 1976, through September 30, 1980.

DPW Rule 49 — Regulations of the Minnesota Department of Public Welfare for Determining Welfare Per Diem Rates for Nursing Home Providers under the Title XIX Medical Assistance Program — establishes a terribly complex, although apparently thorough, system for the determination of per diem welfare rates for all nursing homes participating in the Minnesota Supplemental Aid Program. Attachment B to Joint Exhibit 32.

Section 249 of the Social Security Act, 42 U.S.C. §1396a(a) provides:

> A state plan for medical assistance must —
>
> * * *
>
> (13) provide —
>
> (E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost-related basis, as determined in accordance with methods and standards which shall be developed by the state and the basis of cost-finding methods approved and verified by the Secretary.

Plaintiffs contend that the reimbursement provided under Rule 49 is not "reasonable and cost-related" and that the Rule fails to reimburse even the most efficiently operated nursing homes.

This contention is, of course, the heart of plaintiffs' case. They contend that the medical assistance rates paid by the State are so low that nursing home operators are being driven out of business.

Final regulations issued by the Secretary of HHS define a "reasonable cost-related" rate of payment as a rate which will fully compensate an efficiently run nursing home for its "actual allowable costs."

Plaintiffs point to a number of exhibits — The MSRI Study, Ps' ex. 1, and the revised MSRI Table V, Ps' ex. 18, for instance — contending that they establish that the Minnesota System fails to reimburse the average nursing home's actual total costs incurred in providing required nursing care.

All parties admit that the MSRI Study is one of the most important pieces of evidence in this case. That report — entitled A Statistical Study of Rate Setting under Rule 49 — was prepared in 1978 for plaintiff Minnesota Association of Health Care Facilities, Inc. It is an exhaustive statistical analysis of Rule 49 cost reports filed by more than 370 nursing homes in Minnesota. MSRI says in the introduction to this study that the purpose of this data analysis was to "show monetary impact overall, as well as impact on seven cost adjustment categories."

Rule 49, it will be remembered, employs a prospective rate setting methodology. That is, the medical assistance rate is established by reference to anticipated operating costs. in order to establish its rate for next year, a provider files a Rule 49 cost report with the State Department of Public Welfare. In that report, the provider sets out historical operating costs and other operational data of the facility. These historical costs are limited by a number of caps, continued in the Rule. For instance, there are absolute limits on the amount of money that a nursing home can pay its top management and seek full reimbursement through the welfare rate. In addition, the historical costs are allowed to be modified by certain "cost changes" both known and unknown. Finally, the overall rate may be subject to regional maxima. Jt. ex. 32.

An operator must file the cost report by the end of the first quarter of the year in question. This report contains the required operating information, including historical costs the proposed cost changes and occupancy data. The cost report contains a "requested" or proposed new welfare per diem rate. See, for example, Joint Exhibit 59e, p. 15, line 9. then sets a temporary rate for the home: the historical rate plus 80 percent of the requested increases.

Every cost report is then subjected to a desk audit: an in-agency review and examination by DPW auditors. The Rule 49 limitations are imposed and a final rate is established. This final rate is retroactively effective to the first day of the year in question, even through it is probably not established until well into the year.

In addition, field audits are conducted on a number of facilities each year. These are more exhaustive reviews of the books and records of the facility to determine whether the costs reported are reasonable and related to patient care.

These cost reports are the source of the data analyzed by MSRI. Ps' ex. 1, at 11-14. It is important to note, that in its data collection efforts, MSRI ignored the balance sheets and operating statements filed as part of the costs reports. *Id.* at 6. The revenue figures used by MSRI were apparently based on the welfare rate (prospective) and the historical occupancy rate (private and welfare). *Id.*

Table V of the MSRI study, reproduced below, illustrates the effect the internal Rule 49 limitations have on the costs allowed to be considered in determining the welfare rate. As can be seen, the *average* DPW allowed cost item is less than the *average* facility claimed cost item. In addition, the average revenue[4] is further limited by the application of regional maxima.

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[4]Not average revenue extracted from the operating statements filed as part of the cost reports, but rather a "computed" average revenue. *Id.* at 35-36.

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Cost Items (Area of Adjustment)	Average Per Books Costs Per Home	Average DPW Allowed Costs Per Home	Difference
Interest Expense	$27,595.25	$25,013.53	$2,581.72
Top Management Compensation	16,717.46	14,894.95	1,822.51
Total Costs	553,754.19	539,831.69	13,922.50
ALLOWED COSTS PER HOME			
Nursing Costs	$187,637.81	$186,595.06	$1,042.75
Known Cost Changes	55,027.22	52,899.08	2,128.14
Fixed	10,991.18	10,363.56	627.62
Variable	44,036.04	42,535.52	1,500.52
Cost of Capital	17,740.29	17,937.15	(196.86)
Investment Per Bed (Disallowed)	(469.02)	(478.71)	(9.69)
REVENUE ITEM	**Average Revenue Calculated w/o Regional Maximum**	**Average Revenue Calculated With Regional Maximum**	
Average Revenue Based on Actual Patient-Days and Equalization	$610,331.88	$608,311.00	$ 2,087.38

In summary, Table V shows that on average, $13,922.50 of a facility's costs are disallowed by DPW during the rate determination process. Each of the seven specific internal Rule 49 limitations — cost changes, regional maxima, nursing hours, top management compensation, investment per bid, interest expense and cost of capital — on average, limited the rate eventually paid to the "average" home. Appendix VII to the MSRI Study provides the detail for the comparisons set out in Table V.

This evidence indicates that for the average facility, costs would exceed revenues (assuming equalization of the welfare and private pay rate) by about $400.00. *id.*, Ps' ex. 19. It is based on this evidence and the opinion testimony of expert Richard Kahan, which is predicated in large part on the data analyzed in MSRI, that plaintiffs argue that the Minnesota Medicaid Reimbursement System was not reasonable cost-related.

Plaintiffs suggest that because the system does not reimburse in full all expenses incurred in connection with the provision of nursing home services, it is not reasonable cost-related. While that argument appears, at first blush, to be well founded, it does not withstand close analysis.

In order to see this, it is necessary to distinguish between an item of expense which may be "allowable" but not reimburseable. Food costs are, of course, allowable items of expense under Rule 49. Yet no one would suggest that if the nursing home chose to serve steak rather than hamburger, that its full food expense should be recoverable through the welfare rate. Adequate care and comparable nutrition could be provided at a lower rate.

Likewise, the state could conclude that, if hamburger could be purchased for $3.00 per pound, an expenditure of $4.00 per pound for hamburger is unreasonable and should not be fully reimbursed. It was the intent of Congress to encourage economic control in the Medicaid Program when it adopted the reasonable cost-related standard. 43 Fed. Reg. 4862 (Feb. 6, 1978). The reasonable cost-related standard does not require that the State reimburse providers in full for allowable costs incurred. *Minnesota Association of Health Care Facilities, Inc. v. Minnesota Department of Public Welfare, supra* at 153; *Illinois Council for Long Term Care v. Miller*, 503 F.Supp. 1091, 1095 (N.D. Ill. 1980).

Finally, the prospective nature of Rule 49 comes into play. Simply because a cost item is disallowed does not mean that an actual item of expense has been disallowed. An efficient operator will see that a proposed cost will not be allowed and determine a way to budget around the problem. The Deloitte Study, D's ex. 1a and 1b, indicates that over 99 percent of the nursing home expenses attributed to Medicaid were reimbursed by Rule 49 during the years under study.

Careful review of the record in this case indicates that the interpretation of the reasonable cost related standard advocated by defendants — only those reasonable and allowable costs which are related to the efficient and economical delivery of care — has been adopted by HHS, and the District Court and the Court of Appeals in earlier decisions in this cause. Based on that interpretation, it is clear that plaintiffs have not established by a preponderance of the evidence that Rule 49 is not reasonable cost-related.

2. From and after October 1, 1980, the Minnesota Medicare Reimbursement System did not pay for skilled nursing and intermediate care nursing services at rates which were reasonable and adequate.

In December 1980, the Boren Amendment modified §1396. Retroactive to October 1, 1980, the State Plan must provide for reimbursement at rates

> which the state finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws. . . .

Thus the "reasonable cost-related" standard was replaced by a "reasonable and adequate" standard. Plaintiffs contend that Rule 49 does not measure up to this standard. Plaintiffs contend that DPW determines the Rule 49 rate and then defines an "efficiently and economically operated" facility as one which can live with the predetermined welfare rate. The Boren Amendment requires the state to define "efficiently and economically operated" facility by reference to extrinsic evidence and then set the welfare rate so that it adequately reimburses all reasonable costs incurred by such a facility. Pointing to the MSRI Study and the testimony of Dr. Kahan, plaintiffs suggest that the evidence establishes that many economically and efficiently operated facilities cannot meet their operating expenses based on the Medicaid rate. Thus Rule 49 is in violation of federal law.

Defendants contend that the Boren Amendment reduces the level of reimbursement required under federal law. Therefore, because Rule 49 satisfies the pre-Boren "reasonable cost-related" standard, it passes muster under *Boren*.

The position taken by HHS, the agency charged by law with supervising this program is that any plan which satisfies the "reasonable cost-related" standard satisfies the Boren standard. Jt. ex. 32, letter 5/20/81 to "The Honorable Judge Edward J. Devitt" from Attorney Yourman, Health Care Financing and Human Development Services.

The evidence does not support plaintiffs' conclusion that DPW has arbitrarily set the medicaid reimbursement rate and then defend an economically and efficiently operated facility be reference to that rate. The evidence presented by defendants in the Deloitte Study suggests that most operators are able to recover their allowable expenses in full through the Rule 49 mechanism. Thus because the cornerstone of plaintiffs' argument — that the M.A. rate was arbitrarily set — is unfounded, the whole argument collapses.

3. The Minnesota Medicaid Reimbursement System has not been approved by The Department of Health and Human Services as required by federal law.

On December 24, 1980, the District Court entered an order directing the Department of Health and Human Services to review the Minnesota Plan. In a report submitted to the Court in May 1981, Jt. ex, 32, the Health Care Financing Administration of HHS, concluded that the plan was reasonable cost-related and thus satisfied the requirements of federal law.[5]

Plaintiffs attack both the procedures employed by HHS during this review and the conclusions drawn by the agency after the review.

The District Court's order required HHS "to test the validity of the State plan in practice. . . ." Memorandum and Order, December 24, 1980, at 4. However, this order of reference was based on 42 U.S.C. §1396a(a)(13)(E). The Department of Health and Human Services was required by that section of the law to review and verify (i) the cost finding methods utilized in the state plan and (ii) the rate setting methodology used in the State plan in order to insure that it would result in reasonable cost-related reimbursement. *Alabama Nursing Home Association v. Harris*, 617 F.2d 388, 393 (5th Cir. 1980).

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[5]The HCFA concluded that "the provisions of the plan are reasonable cost related . . . ." Because HHS had "taken the position that any plan which was approvable under the former 'reasonable cost related' standard continues to be approvable under the [Boren Amendment]" review under the new standard was not necessary.

In the *Alabama Nursing Home* case, the Court of Appeals reversed the District Court and held that HEW had failed to review and validate the Alabama long term health care Medicaid reimbursement plan as required by §1396a(a)(13)(E). The Alabama plan — which essentially "provides for prospective reimbursement . . . and fixes a ceiling on reimbursement equal to the projected billing rate of the sixtieth percentile facility in each class" *id.* at 391 — was approved "solely from the application of the agency's institutional assumption that any plan that reimburses at or above the projected billing rate of the median facility in a class meets the regulatory minimum reimbursement rate." *Id.* at 394. The Court of Appeals held, however, that "[t]he application of such an assumption does not satisfy the requirements of §1396a(a)(13)(E)." *Id.*

The case was remanded to the District Court with instructions to

> [r]efer the Alabama reimbursement plant to HEW for compliance with its regulatory duties. The district court should retain jurisdiction over this action to ensure that HEW develops specific criteria and standards regarding both 'an economically and efficiently operated' facility and reasonable reimbursement classes. Additionally, the district court must ensure that HEW develops criteria and standards by which it is to determine whether the reimbursement rate specified in the [Alabama plan] is within the prescribed range of reasonable cost related reimbursement.

Id.

In response to the first of the criticisms mentioned above, HHS has developed Standardized Review Criteria for Title XIX Long-term Care Payment Plans, Jt. ex. 33, which were applied during the verification process here. Jt. ex. 32, at 1. Included in these review criteria are procedures to be employed by HHS to meet the second objection articulated by the *Alabama Nursing Home* Court. Jt. ex. 33, at 3.

In conducting its review and validation of Rule 49, HHS conducted an in depth study of the Rule and the operation under it. It reviewed the entire plan (initial review — Attachment A to Jt. ex. 32) and then solicited comments and information from both sides to this litigation on a number of occasions.[6] See, Jt. exs. 34-38 and Jt. ex. 32 — Memorandum Streimer to Yourman, May 15, 1981, at 1. Four individuals spent over 400 hours reviewing the Minnesota Plan and the additional data submitted by the parties.

Plaintiffs challenge the review process on a number of different grounds, suggesting that each is enough to support a conclusion that HHS has not satisfied the requirements of §1396a(a)(13)(E).

First, plaintiffs observe that Judge Devitt's referral order requires verification by HHS of whether Rule 49 provides for the required reimbursement for the period July 1, 1976, to October 1, 1980. However, HHS did not do any plan review for the period July 1, 1976, to January 1, 1978.

In response, both defendants and HHS[7] point out that Minnesota did not have an approved reimbursement plant prior to January 1, 1978. Thus, prior to that time, there was nothing for HHS to review and validate. In addition, the MSRI Study, Ps' ex. 1, submitted to the HHS reviewers, is based principally on pre-January 1, 1978 data. Thus, HHS had that information available to it when it conducted the review.

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[6]Although there is no independent duty on the part of HHS to consider data submitted by providers, *Hospital Association of N.Y. v. Toia*, 473 F.Supp. 917, 922 (S.D. NY 1979), it did receive and consider evidence, including the MSRI Study and the Kahan affidavit, supplied by plaintiffs.

[7]In a letter to the District Court (Yourman to The Honorable Edward J. Devitt) dated June 16, 1981.

As will be pointed out below, it is this court's conclusion that HHS has complied with the requirements of §1396a(a)(13)(E). The Minnesota Plan has been reviewed and verified by HHS as required by statute. However, plaintiffs seem to argue that the question of whether HHS has complied with Judge Devitt's reference order is independent of the question whether the statute has been satisfied.

Assuming that distinction can be made, and assuming that some relief could be granted plaintiffs if Judge Devitt's order has not been fully complied with, it is necessary to deal with this contention.

Judge Devitt concluded that HHS had, prior to his order of reference, not "fulfilled its statutory [§1396a(a)(13)(E)] duty to verify the reasonable cost-relatedness of the *Minnesota State Plan*" Memorandum and Order, December 24, 1980, emphasis supplied. Although there is a reference to the time period beginning on July 1, 1976, it is clear from a reading of both Judge Devitt's orders on this subject that what he wanted analyzed by HHS was the Minnesota State Plan. Because, there was no approved Minnesota State Plan until January 1, 1978, a review beginning on that date is adequate and in compliance with Judge Devitt's orders.

In addition, plaintiffs challenge the scope of the plan review. Brief of Plaintiffs and Plaintiff-Intervenors at 51-66. There is a presumption of validity which attaches to the review action here and plaintiffs have the burden of rebutting that presumption. *Alabama Nursing Home Association v. Harris, supra,* at 393. Although plaintiffs can point to mistakes and miscalculations, they have not established anything which establishes that this review and validation process was invalid. In the orders of reference, it is clear that the District Court was seeking to bring to bear on the issues here the expertise of HHS. Because of that Judge Devitt refused to prescribe the procedures to be followed. It was to "apply its own methodology" and use "flexible procedures" in the conduct of this review.

A review of Jt. ex. 32 demonstrates that HHS clearly understood Rule 49 and its application. The agency has developed standards for conducting a review as required by *Alabama Nursing Home*, Jt. ex. 33, and applied those standards here. It is the agency's judgment that Rule 49 satisfies federal law. Based upon the evidence presented, the procedures employed by HHS in conducting this review and verification cannot be challenged.

V. CONCLUSION

This has been an arduous process for the litigants. These lawsuits, originally filed in mid 1977, are only coming to decision today.

The providers who testified were indeed impressive witnesses. Their story is one of small businesses struggling in a heavily regulated industry. However, their complaints about the scope and intensity of that regulation must be brought in the legislative forum. They have not established their constitutional claims nor their claims that federal law has been violated. Consequently, these lawsuits must be dismissed.

Dated April 26, 1983.

Brian P. Short
United States Magistrate

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